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**Factors affecting the social and affiliative needs of people suffering from long-term mental health problems: A qualitative project comparing the social needs of people suffering from schizophrenia or depression**

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Submitted in partial fulfilment of the requirements for the degree of  
**Doctorate of Clinical Psychology**

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## **ABSTRACT**

**Objectives:-** Research examining the relationship between social support and long-term mental illness has, on the whole, failed to address the complexity of the processes involved in receiving support from relationships. As a result, few clinical implications have arisen from the research. The aim of this study was to gain a more detailed understanding about the nature and complexity of the factors that make it difficult for people with long-term mental health problems to form relationships with others and to utilise the social support that is potentially available. The study recruited participants who were suffering from schizophrenia or depression. The comparative element of the design aimed to provide an increased understanding of how the psychiatric disorders impacted on people's perceptions of their relationships, and how their relationships impacted on their emotional difficulties.

**Design:-** The study employed a qualitative research paradigm using a grounded theory methodology.

**Method:-** Two groups of participants were sought. One contained participants suffering from the symptoms of schizophrenia but not depression (the S group). The other contained participants suffering from severe unipolar depression (the D group). Face to face interviews were conducted using semi-structured interview schedules. The interviews aimed to develop a greater insight into users' perceptions of their past and current relationships, their beliefs about what friends are for and the way they form friendships, the types of interpersonal problems experienced, perceived contributory factors to these interpersonal difficulties and the nature of the support desired to help overcome them.

**Results:-** Participant responses were analysed using aspects of the grounded theory method. Codes, categories and themes were generated from the data. Some themes were common to both groups. Others reflected important differences between them.

**Conclusions and Implications:-** A tentative theoretical framework was developed to account for the responses given by the two groups to the research questions. The data generated from the responses given by S group participants suggested they had difficulties in reflecting on their own or others' mental states (i.e. difficulties in 'reflective functioning'). This had important implications not only for the way the S group described and made sense of their relationships, and could account for some of the different themes generated by the two groups, but also pointed to several new intervention strategies (particularly strategies for overcoming this group's social skills deficits). In contrast, the responses given by the D group suggested they had fewer difficulties in 'reflective functioning'. Rather, it appeared that negative internal working models of caring relationships, formed from earlier experiences in their family, had resulted in a deep suspicion of close relationships and a continued anticipation of betrayal and rejection. This theory also accounted for some of the different themes that emerged between the two groups. It also pointed to intervention strategies for the D group.

These theories have been incorporated into, and contrasted with, existing theory and research developments. Hypothesised developmental frameworks have been proposed to account for the data. Methodological and conceptual issues in the research have also been addressed and suggestions made for future research.

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# **1. INTRODUCTION**

## **1.1 Overview**

For many years the majority of services provided for people suffering from severe and long-term mental health problems were dominated by a medical model of care (Bond and Lader, 1996). At the core of the medical model lies the assumption that the symptoms of most forms of long-term emotional distress can be categorised into recognisable patterns of abnormal behaviour and that these reflect some underlying genetic, neuroanatomical or biochemical dysfunction. As a result of this core assumption, empirical research into long-term mental health problems traditionally placed little emphasis on the impact of social relationships on the aetiology and maintenance of such 'disorders'.

More recently this 'disease' model of mental illness has been modified by the growth of specialities such as transcultural and social psychiatry. This has led to the development of interactional and vulnerability models of mental illness (e.g. Zubin and Spring, 1977; cited in Clements and Turpin, 1992) which emphasise the role social relationships play (via social support) in *mediating* against the effect of environmental stressors, which in turn interact with genetic, biochemical or neuroanatomical vulnerabilities to produce symptom formation. These models have resulted in research examining both the characteristics of the social networks of people suffering from long-term mental illness and the influence of such networks on the aetiology and course of the illness.

Yet there are many problems with such studies. In particular, they say little about the complexity of the processes involved in receiving support from relationships. It is now becoming widely accepted that 'social support' is a personal experience, as opposed to a set of objective circumstances (Buchanan, 1995). Of all the various measures of social support it is perceived social support that appears most closely associated with health (Sarason, Pierce and Sarason, 1990). Yet, by concentrating largely on structural aspects of support, the literature has so far failed to address the issue of

individual differences in the need for social support. An individual's need for social support, or their perceived levels of social support, will vary according to a variety of factors including their attachment history, coping styles, expectations of relationships, interpersonal problems and the situations in which the support is received. Different types of support functions may be important for different people, suffering from different types of emotional distress, in different types of relationships. Some people may have adequate support resources, but are reluctant to use them. Clearly it is difficult to determine the varying impact of these variables in quantitative studies where individual data is aggregated. Yet, crucially, if research into the social relationships of people with long-term mental health problems is to have practical implications, then we need to be aware of the complexity of the issues involved and the personal meaning of support for those receiving it.

There are several alternative theoretical approaches to the medical model which can throw light on the complex processes involved in forming, receiving and utilising support from relationships. A number of these are reviewed. Unfortunately, the domination (and resulting power) of the medical model (with its biological and neuroanatomical emphasis) has resulted in less attention, and fewer financial resources, being invested in these alternative research programmes. Yet several convincing arguments have been developed, particularly by authors such as Bentall (1990) and Boyle (1994), which emphasise the importance, and potential benefits that might be gained, by adopting these alternatives. These arguments are also reviewed.

The question remains as to how to best investigate the impact of social relationships on the aetiology and course of long-term mental illness, and to conduct studies which might inform intervention strategies. The overall aim of this study was to develop a greater insight into users' perceptions of their past and current relationships, the importance, benefits and negative aspects of particular relationships, their beliefs about what friends are for and the ways they form friendships, the types of interpersonal problems experienced, perceived contributory factors to these interpersonal difficulties and the nature of the support they would like (if any) to help overcome them. It used a qualitative research paradigm using a grounded theory methodology. Arguments for

adopting such a research paradigm are presented. The study contrasted the views of two particular groups of users; those suffering from the symptoms of schizophrenia and those suffering from severe unipolar depression. The comparative element within the design aimed to provide an increased understanding of how the symptoms of the two different psychiatric disorders impacted on people's perceptions of their relationships, and how their relationships were perceived to impact on their emotional difficulties.

## **1.2 Defining Social Support**

Most studies investigating the impact that social relationships have on mental health have used the term 'social support'. Therefore, before reviewing the relevant literature it is important to clarify the term. 'Social support' is an omnibus term rather than a unitary concept. This is reflected in the wide range of approaches to, and measures of, social support. Sarason, Sarason and Pierce (1990) argued that the current approaches and available measures of social support fall into three categories: 1) the network model that focuses on the individual's social integration into a group; 2) the received support model that focuses on what the person actually received or reports to receive; and 3) the perceived support model that focuses on the support the person believes to be available if he/she should need it. Unfortunately these models and assessment tools measure different things and show different relationships with different predictor variables (Brugha, 1995). Significantly, recent work has suggested the aspect of social support that is most closely related to health outcomes is perceived support (Sarason, Pierce and Sarason, 1990).

## **1.3 The Relationship between Social Support and Long-Term Mental Illness**

Considerable research has been conducted on the inter-relationship between social support and depression. This is perhaps because depression affects so many people, most of whom do not require long-term psychiatric treatment. Much of this work has been conducted on non-clinical participants. Much less work has been conducted on the inter-relationship between social support and schizophrenia.

### 1.3.1 Social Support and 'Depression'

Numerous studies have examined the social support networks, and the effects of informational support, instrumental (or tangible or material) support and emotional (or esteem enhancing) support, on the symptoms of depression (see Brugha, 1988). Most studies found that people suffering from both mild and more severe endogenous types of depression had significantly deficient social support networks (e.g. Brugha, Sturt, MacCarthy, Potter, Wykes and Bebbington, 1987), although the social networks of long-term psychiatric patients were smaller than those suffering from acute episodes (Brugha, Wing, Brewin, MacCarthy and Lesage, 1993).

Social support appears to have an important influence on the *onset* of the disorder. For example, Brown and Harris (1978) found that the presence of a confidant (i.e. a spouse, boyfriend or close friend) protected women in the community from developing depression (results confirmed by Brown, Andrews, Harris, Adler and Bridge, 1986). Power (1988) found that measures of social and practical support were significant predictors of depression and total symptom scores measured at a six month follow up. Miller, Ingram, Kreitman, Surtess and Sashidarhan (1987) interviewed 333 women in the general population at three points over one year. Their work showed that impaired social relationships predicted the onset of the disorder even when self-esteem and life events were controlled for.

Studies also suggest that social support plays an important role in *recovery* from depression. Brugha, Bebbington, MacCarthy, Sturt, Wykes and Potter (1990) investigated the relationship between the types of social relationships and social support (assessed on the Self Evaluation and Social Support Schedule; O'Connor and Brown, 1984), and subsequent recovery in 120 depressed patients. The relationships were complex. For example, being in a marriage was related to better recovery only in men and having a larger number of close relatives and good friends was related to subsequent recovery only in women. George, Blazer, Hughes and Fowler (1989) followed up 155 middle aged and older adults with a diagnosis of major depression

over a period of 6-32 months and found that subjective social support was significantly related to subsequent outcome.

### 1.3.2 Social Support and 'Schizophrenia'

The interactional model of mental illness formed the theoretical basis for several research studies which have examined the social networks of people suffering from schizophrenia and the relationship between these and the course of schizophrenia (e.g. number and length of hospitalisations, level of social functioning and symptomatic distress). Most of this research concentrated on *structural* aspects of support (i.e. the number, type and organisation of someone's social contacts). In general the research suggests that people with schizophrenia develop more limited networks that tend to be dependent on family or mental health services and relationships in which they are the recipients of support, but most often not providers (Sullivan and Poertner, 1989). Whereas several studies have reliably shown that the primary networks of a 'normal' sample consist of about 40 persons seen regularly, of whom 6-10 are known intimately (Henderson, Bryne and Duncan-Jones, 1981), the social networks of people with schizophrenia are only of 4-5 people seen regularly, usually family (McFarlane, Neale, Norman, Roy and Strener, 1981; both cited in Cresswell, Kuipers and Power, 1992).

Current research clearly suggests that social support and social functioning have important mediating roles in the *course* of schizophrenia. Epidemiological studies have shown that frequent admissions to psychiatric services are correlated with social isolation (Cresswell et al. 1992). As part of the World Health Organisation (WHO) research into schizophrenia, Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day and Bertelsen (1992) found that good social contact was one of the main predictors of favourable outcome. Faccincani, Mignolli and Platt (1990) in a 7-year follow-up study of people with 'schizophrenic psychosis' found that those people with greater levels of social support (defined as confiding relationships, personal assets, environmental assets and positive home atmosphere), had improved social functioning, improved symptomatology and reduced dependence on inpatient facilities.

## Schizophrenia and the family

Studies evaluating the impact of social relationships and social support on the *onset* of schizophrenia have proved more controversial. In the late 1950's and 1960's a range of literature emerged which proposed that dysfunctional parenting styles caused schizophrenia. Fromm-Reichman (1948) argued that schizophrenia arose in families with a cold, rigorous, sadistically aggressive, 'schizophrenogenic' mother and a soft, indifferent and passive father. Bateson, Jackson, Haley and Weakland (1956) argued in their 'double bind hypothesis', that deviant, internally-inconsistent communication by parents led children to use psychotic behaviour as a coping response. More recently, Lidz (1993) has argued that schizophrenia arises in a chaos-inducing family environment and a 'milieu filled with inconsistencies, contradictory meanings and the denial of what should be obvious'.

Many researchers argued that these views not only had little empirical support (e.g. Leff, 1982) but were damaging because relatives were stigmatised for the patient's illness. A different set of theories emerged which were labelled the 'family management approach'. These theories emphasised that although families do not cause the disorder, they can play a role in preventing relapse. Brown, Birley and Wing's (1972) concept of 'Expressed Emotion' (EE) is central to the research. Numerous studies (summarised in the meta-analysis of Mari and Streiner, 1994) have shown that patients with schizophrenia who have relatives rated highly on scales of hostility, critical comments and over-involvement (referred to as high EE) are significantly more likely to relapse than patients with relatives characterised as having low EE. This has led clinicians to devise intervention packages with families to reduce levels of EE and hence the rate of relapse. Such approaches have educational components, behavioural family management approaches (including strategies to deal with difficult situations without resorting to high EE) and emphasise compliance with medication. In general, critical comments and hostility appear more easy to modify whereas over-involvement is more resistant to change (Lam, 1991).



## **1.4 The Limitations of the Current Research**

### ***(i) Where is the human reality?***

One of the primary problems with existing research is that people and their relationships are studied as if they are objects exhibiting a collection of behaviours. There are few glimpses of human reality and personal meaning (Johnstone, 1993). For example, in the family management literature, what does high EE really mean? Why do relatives react in this way? How do patients feel in the face of these critical remarks? How does the over-involvement start and why is this the most difficult aspect of high EE to change or modify? Perhaps, as Johnstone (1993) points out, traditional psychiatry cannot afford to ask these questions, for to 'discover that high EE on the one side and symptomatology on the other are meaningful and intelligible aspects of human relationships, is to threaten the status of schizophrenia as an illness and medicine as the discipline to treat and control it'.

### ***(ii) The complexity of the processes involved in receiving support from relationships***

Unfortunately, despite the social support research that has accumulated over the past decade, the process by which social support accomplishes a health protective function is neither clearly understood nor adequately documented. As a result, little is understood about why the relationship should exist. Two theories take prominence in the literature. The 'buffering' or 'stress specific' hypothesis argues that social support has an indirect impact on the course of an illness by buffering the effect of stress. The 'universal effect' model takes a different view and argues that high levels of social support are associated with better health even in the absence of stressors (Cohen, 1988). Although some empirical support exists for both models, neither has been strongly or consistently demonstrated (Buchanan, 1995). A major problem in testing the 'stress specific' hypothesis has been the lack of attention given to the circumstances in which the perception of support and the adaptational consequences arise. Social support may buffer the effects of stress, but only in certain circumstances. Similarly, whilst social support may be associated with better health even in the

absence of stressors (the universal effect model), the relationship is likely to be 'complex, reciprocal and contingent' (Coyne and DeLongis, 1986, p. 454). According to Lieberman (1986), 'the findings used to summarise and theorise about social support have become overly inclusive and need to be disaggregated into a number of component parts' (p.464).

Current research reveals little about the nature and the complexity of the relationship between social support and long-term mental illness. Traditionally the assumption has been that people who are supported instrumentally and emotionally are healthier than those who are not supported. There is now convincing evidence that some forms of support are potentially harmful (Gibson, 1992). This may occur when supportive actions are not consistent with either a person's expectations or their coping style. For example, when Brown and Harris (1978) surveyed women on a Scottish island they found that whilst a local type of strongly integrated social support system appeared to protect against depression it was also conversely strongly associated with anxiety. Wing (1978; cited in Burbach, 1996) suggested that social withdrawal may actually be protective for some people with schizophrenia who have damaged social skills. Social isolation may assist them to maintain a psychological balance between excessive and deficient social stimulation and prevent them being overwhelmed rather than supported by their connections (Hirschberg, 1985). Lehman (1980), who studied people with schizophrenia who were living in Manhattan single room hotels, found strong associations between life satisfaction and high social functioning in those who had casual rather than nurturing relationships in the hotel. Cresswell, Kuipers and Power (1992) found that although the primary networks of a group of schizophrenic patients were small, comprising on average seven members of whom three were seen regularly, they rated their perceived support as adequate.

Clearly, the literature has, for the most part, failed to address the issue of individual differences in the need for social support. Different types of support functions will be important for different people, suffering from different types of emotional distress, in different types of relationships. Clearly it is difficult to determine the varying impact of these variables in quantitative studies where individual data is aggregated.

### ***(iii) Clinical implications***

As current research has yet to address the complex nature of social support and the personal meaning of support for those receiving it, the research has little relevance to intervention (Coyne and DeLongis, 1986). In fact there have been very few studies which have attempted to evaluate the effects of enhancing personal social support networks, or of enhancing the ability of individuals to recruit support, in people with long-term mental health needs (Stewart, 1989). Some studies have evaluated social skills training for this group. Yet, whilst gains have been made in the treatment context, these gains rarely generalise to other contexts and situations (Smith, Bellack and Liberman, 1996). Corrigan (1991) conducted a meta-analysis of studies evaluating the effectiveness of social skills training and concluded that treatment rarely reduced later psychiatric symptom levels. Moreover, there is only limited evidence that such training results in overall social adjustment (Smith, Bellack and Liberman, 1996). Many questions in the social skills training literature remain unanswered. For example, why do this group have deficient social skills? To what extent do deficits in social skills contribute to symptoms and to what extent do symptoms contribute to deficits in social skills? If the outcome of social skills training is to be generalised beyond the treatment setting, then we need to know more about the range of factors that impinge on a person's ability to relate to others (Sheppard, 1987). This will enable us to develop more comprehensive and focused intervention packages.

### **1.5 Enriching our understanding**

In the following sections several alternative philosophical and theoretical traditions are reviewed which have the potential to enrich our understanding about the range and complexity of the factors that impact on a person's ability to form social relationships and to utilise the social support available. The literature suggests some key differences for people who are suffering from depression compared to those suffering from schizophrenia. The literature reviewed also reflects the authors' preliminary thoughts about the themes that might arise from the research.

## **1.6 Developmental Perspectives**

### **1.6.1 The effects of attachment**

According to attachment theorists, a person's ability to form relationships with others is profoundly affected by their early experiences (particularly of being parented) and their ability to form positive 'internal working models' of themselves and others (Bowlby, 1980). The negative consequences of failures and disruptions in early attachment relationships are believed to express themselves in poor internal models of the self and views of others as unreliable, unavailable and/or harmful (Safran and Segal, 1990). It is generally hypothesised that these internal working models are resistant to change because they tend to be over-learned and operate out of awareness, and because the default strategy for processing information is to assimilate it to existing schema rather than modify schema to accommodate the information.

Serious gaps remain in the attachment literature. For example, we have little knowledge about how child temperament (Kagan, 1989), cultural socialisation practices (Thompson and Lamb, 1986) and the influence of caretakers other than parents (Ainsworth, 1991; all cited in Champion, 1996) influences the formation of internal attachment models. Yet, support for stable internal models comes from the significant associations that have been found between insecure attachment in infancy and difficulties in interpersonal relationships and styles of relating in both childhood (Thompson and Lamb, 1986) and adult life (Horowitz and Vitkus, 1986).

The Adult Attachment Interview (AAI; Main and Goldwyn, 1991) is currently the most detailed and extensive tool for examining the functioning of a person's internal working models. Whilst extensive research has been conducted on people with depression, this tool has yet to be used on people suffering from schizophrenia. In fact surprisingly little research has been conducted on the early parental experiences or attachment models of people suffering from schizophrenia, nor on the impact this has on their relationships. Parker, Fairley, Greenwood, Jurd and Silove (1982) did examine the relationship between early parental experiences (assessed on the Parental Bonding Instrument; Wilhelm and Parker, 1988) and outcome following hospital

discharge in a group diagnosed with schizophrenia. They found that those participants who assigned one or both parents to a low care / overprotection group were more likely to have been readmitted at a nine month follow up.

### **1.6.2 Childhood Relationships**

Skolnick (1986; cited in Champion, 1996) and Ainsworth (1989) found that the quality of childhood peer relationships predicted adult psychological health. Champion (1996) warns that it is easy to underestimate the importance of children's friendships in promoting adaptive working models of supportive social relationships. Whilst attachment models may be crucial in developing models of *emotional support*, the ability to obtain *informational* and *instrumental support* may well be more profoundly influenced by an adult's working models formed from early childhood relationships. It may also be the crucial time in which a person develops social skills and competencies which lead to either greater acceptance or rejection by their peers. For example, in childhood, friends are more likely than family to emphasise the need for reciprocity and obligation. Unfortunately, we know little about how these early experiences of friendships influence the quality of social relationships in adulthood or the types of interpersonal problems experienced. Asher, Erdley and Gabriel (1994) have reviewed studies which indicate that the type of peer relationship difficulty experienced in childhood may determine the sorts of emotional difficulties experienced in adulthood. For example, the experience of loneliness without aggression or active rejection from peers may be associated with 'internalising difficulties' such as depression. In contrast, more aggressive children who experience rejection by their peers may be more likely to develop 'externalising' difficulties such as paranoid schizophrenia. It was hypothesised that these differences might emerge in the course of this study.

### **1.6.3 Object Relations Theory**

Object relations theory provides another way of understanding the difficulties people might have with others (e.g. Greenberg and Mitchell, 1983). The theory proposes that internalised aspects of self and significant others (particularly those formed early in childhood) form the basis for interacting with and understanding others (Greenberg and Mitchell, 1983). These internalised aspects are often projected onto others as a

means of understanding the other's expected and actual behaviour. This has led interpersonal theorists to explore the interpersonal dynamics that lead people to re-enact maladaptive interpersonal patterns in an effort to maintain a psychological tie to an earlier attachment figure. Although these maladaptive relationship patterns often lead to painful experiences, the defensive efforts to avoid anxiety and to protect self-image leads individuals to repeat them.

#### **1.6.4 The Defensive Function of Certain Symptoms**

Object relations theory suggests that the defensive function of certain symptoms may interfere with a person's ability to form adequate relations with others and to utilise the potential support available to them (Frosch, 1986). This is a view supported by other research traditions (e.g. cognitive therapy and other psychodynamic theories). The following brief review examines some of the different ways in which the defensive functions of the symptoms of schizophrenia and depression might impact on the nature of a person's relationships.

Chadwick, Birchwood and Trower (1996) have recently proposed a theory which attempts to explain the purpose and function of the paranoid symptoms of schizophrenia from a cognitive perspective. They propose that paranoid symptoms persist because they serve as defences against low self esteem and a fragile sense of self. Frosch (1986), writing from a psychoanalytic tradition, proposes that the core or basic anxiety underlying the schizophrenic condition is a fear of the disintegration or dissolution of the self. Both theories suggest that close, intimate relationships with others may interfere with these defences. Therefore close relationships may be perceived as threatening, may potentially uncover the fragile sense of self, and will thus be avoided.

Recent advances in both cognitive and psychodynamic theory have distinguished between two types of depression (Blatt and Zuroff, 1992). The first is a depression focused on interpersonal issues such as dependency, helplessness, and feelings of loss or abandonment ('anaclitic' depression). The second focuses on issues of self-definition such as autonomy, self-criticism, and feelings of failure or guilt ('introjective'

depression). In the first case, depression is seen as a defence against the anger that might threaten to destroy the relationships they have with others. Separation from others and loss are sources of considerable fear and apprehension. Blatt and Zuroff (1992) suggest that this group attempt to minimise overt conflict by conforming to and placating others. In the second case, individuals have a chronic fear of criticism, or of losing the approval and acceptance of significant others. They strive hard for achievement and the approval it provides, and fear disapproval and loss of control and autonomy. The emphasis upon separation and individuality means that their interpersonal relationships are likely to be superficial, distant and less emotionally involved (Zuroff and Mongrain, 1987).

## **1.7 Cognitive Perspectives**

Brewin (1995) argues that support seeking depends on a variety of factors, both social (e.g. the availability of support) and cognitive (e.g. the appraisal that support is worth seeking). The possible implications of cognitive factors such as social competence beliefs and social comparison on a person's ability to seek and utilise social support is explored below.

### **1.7.1 Social competence beliefs**

Social anxiety may be so intense that the mere presence of people leads to social withdrawal. Shy and lonely people tend to attribute interpersonal failures to internal, stable, and uncontrollable factors such as lack of social ability (Teglas and Hoffman, 1982; cited in Brewin, 1995). Given that these kinds of attribution lead to low self-esteem and to low expectations of success then this, in turn, reduces the amount of effort expended to initiate and persist at social encounters. This is likely to be relevant to many people suffering from the symptoms of long-term mental health problems.

### **1.7.2 Social comparison**

A person who feels inferior to members of society, or who may suffer stigmatising reactions from others, may make a conscious decision to isolate themselves (Goffman, 1986). However, in the absence of continued rejection, how does a person arrive at

the conclusion that their attitudes or experience make them different and inferior? According to social comparison theory (Festinger, 1954), and rank theory (Gilbert, 1995), people who want to evaluate themselves first seek objective information and then turn to social comparison, preferring to compare themselves with similar others. They will avoid what appear to be 'superior' people because this leads to negative self appraisal. Social comparison theory therefore suggests that people suffering from emotional distress or psychopathology (e.g. depression) will avoid 'normal' (i.e. dissimilar) people. Instead they may seek out those who they perceive as being 'equally deviant' (e.g. through a self-help group) whilst minimising contact with the 'normal' population (Brewin and Furnham, 1986). As a consequence, perceiving few sources of support may be a consequence of the difficulty in finding suitable people, rather than indicating a desire to avoid people generally.

### **1.8 The Influence of Stigma and Hospitalisation**

The stigma that has invariably been attached to people with psychiatric disorder may be yet another factor which contributes to low levels of social support. This may be compounded by the disruptive effects of repeated hospitalisations. Holmes-Eber and Riger (1990) found that patients with repeated hospital admissions and long hospital stays had networks composed of fewer friends and relatives, but more mental health and service professionals, and more acquaintances met in a mental health context.

### **1.9 Summary**

The preceding review suggests that the social and affiliative needs of people with long term mental health problems have not been well documented in the empirical literature to date. Clearly, there is a need to address both the ways in which social support functions for this group and to determine "ways in which this population can be supported in the development of a network of friends" (Liberman, 1986). Norbeck and Tilden (1988) urge that research should move beyond attempting to prove that social support is an important variable, to finding out how social support works for particular groups of people and how to remediate low levels of support. Brugha



(1995) argues that the most valuable information about determinants or causes may come from a careful and systematic exploration of the person's field of close and important social relationships, with particular emphasis on examples of negative and conflictual interaction, and on the person's appraisal of their relationships with others.

### **1.10 Research Aims**

The overall aim of this study was to develop a greater insight into users' perceptions of their past and current relationships, the importance, benefits and negative aspects of particular relationships, their beliefs about what friends are for and the way they form friendships, the types of interpersonal problems experienced, perceived contributory factors to these interpersonal difficulties and the nature of the support they would like (if any) to help overcome them. The study aimed to contrast the views of two particular groups of users; those suffering from the symptoms of schizophrenia and those suffering from severe unipolar depression. The comparative element within the design aimed to provide an increased understanding of how the symptoms of the two different psychiatric disorders impacted on people's perceptions of their relationships, and how their relationships were perceived to impact on their emotional difficulties.

Having formed these research aims the next stage was to decide which research methodology was most suited to the investigation of the complex array of factors that are involved in the perception of support. The rationale for adopting a qualitative approach is outlined below.

### **1.11 Choosing an Appropriate Methodology**

A qualitative grounded theory approach (Strauss, 1987) was deemed to provide the most suitable research methodology given the aims of the research. Grounded theory is based on an inductive approach whereby theory is generated from (grounded in) qualitative data such as personal accounts of experience rather than being a reflection of the researcher's a priori assumptions. It assumes a constructivist epistemology, reflecting a view that knowledge is socially constructed (Strauss and Corbin, 1990). It

provides a logically consistent programme for data collection. It also provides analytic techniques for handling, and making sense of, initially ill structured qualitative data (Henwood and Pidgeon, 1995) and rigorous procedures for researchers to check, refine and develop their ideas and intuitions about it (Charmaz, 1995).

### Practical reasons

Bryman (1988) emphasised the importance of choosing an inquiry position appropriate to the phenomenon to be researched. Qualitative methods are particularly appropriate to an inductive phase of research (Orford, 1995) and to the uncovering of a complex array of meanings and understandings (Banister, Burman, Parker, Taylor and Tindall, 1994). According to Charmaz (1995), they are particularly suitable for studying individual processes, interpersonal relations and the reciprocal effects between individuals and larger social processes. This is because they can address the complexity and the personal nature of the processes involved.

A qualitative methodology therefore provided a powerful approach given that the aims of the research were to gain a more detailed theoretical understanding about the range and complexity of factors that determine the way social support and social relationships function for people suffering from long-term mental illness. The research aimed to use the raw data produced by the semi-structured interviews to generate new theory (Strauss and Corbin, 1990) which might inform different intervention strategies.

A qualitative approach was chosen for two further practical reasons. First, it had been difficult to obtain ethical approval for a quantitative study (see research diary; appendix 9). A qualitative study was deemed less ethically problematic because participants would be better able to control the content and pace of the interviews. Second, ethical constraints would make it difficult to obtain large numbers of participants, particularly given the limited time available. Qualitative methods focus on depth of understanding rather than on issues of generalisability.

### Philosophical reasons

Many writers now make a distinction between a positivist, scientific approach to the generation of knowledge and a postmodernist or social constructionist approach which emphasises that there is no single reality, just different interpretations expressed in a communal discourse (e.g. Charmaz, 1995). Advocates for the later argue that the 'truth' ascribed to different 'realities' are profoundly influenced by the power and knowledge of those subscribing to them. Foucault (1967) emphasises that power/knowledge (the two terms are inseparable in his philosophy) are, in themselves, neither positive or negative. Yet his critical argument is that the assumption of knowledge, or of a particular 'reality', invariably excludes, or at least marginalises, other knowledge and experience (White and Epstein, 1990).

Despite the important implications that might arise from an increased understanding of how social relationships and social support functions for people with long-term mental illness, powerful forces maintain the biological and neuroanatomical focus of the medical model. First, it is the model advocated by psychiatry, currently the most powerful profession in services for the 'mentally ill' (Breggin, 1993). Second, psychiatry is backed by the huge financial and political power of the drug companies who sponsor a great deal of the research into long term mental illness. Third, by labelling long term emotional distress as a 'disease', society, and particularly friends and relatives of those involved, can avoid the issue of blame (Johnson, 1993; Boyle, 1994).

Bentall (1990) and Boyle (1990) have argued that the traditional medical model of research into people suffering from long term mental health problems (their emphasis is on schizophrenia) now represents a 'degenerating research paradigm' and that it is time to abandon our traditional research strategies and move on to potentially more fruitful or 'progressing' areas of research. Boyle (1990) argues that new research paradigms need to be initially protected from their more powerful rivals and treated with a 'methodological tolerance'. Many of these alternative programmes emphasise the functional relationship between behaviour (or emotional distress) and its context or meaning and use qualitative methodologies to uncover the complex relationships

between them. Whilst these qualitative methodologies may not meet the traditional notions of reliability and validity, they provide a more effective way of uncovering new meanings and understandings required for the development of new research traditions.

### **1.12 Research Questions**

In the tradition of grounded theory, no specific hypotheses were stated prior to data collection although the author's preliminary thoughts were outlined in the introduction. The following research questions guided the design of the semi-structured interviews, shaped the course of the interviews, and facilitated the data analysis. Also, by taking an inductive approach, the researcher hoped that other concerns would emerge from the data as the study progressed.

1. What do the two groups of participants feel friends are for and how do they make friends?
2. What interpersonal difficulties do the two groups of participants describe and what views do they express about why these things are difficult?
3. How do the two groups of participants describe their early relationships with family and friends?
4. How do the two groups of participants describe their current relationships with family, friends and mental health professionals and the person they feel closest to in each group?
5. What explanations do the two groups of participants give for the origin of their emotional problems or symptoms?
6. To what extent do the two groups of participants feel that relationship difficulties contributed to their emotional problems or symptoms? Did relationships help them in any way?

7. To what extent do the two groups of participants feel that their emotional problems or symptoms changed their relationships with other people (either in a positive or negative way)?

8. What support do the two groups of participants feel they would like from services to help them overcome the difficulties they describe? How would their relationships with others be different?

## **2. METHOD**

### **2.1 Design**

The study employed a qualitative design using a grounded theory methodology (Strauss and Corbin, 1990). Data was obtained from face to face interviews using a semi-structured interview schedule designed to facilitate the exploration of the research questions.

### **2.2 Participants**

Two groups of participants were sought. One group consisted of people diagnosed with schizophrenia and the other consisted of people suffering from severe depression. Eight participants were recruited to each group.

#### **2.2.1 Sampling issues**

In quantitative research, certain conventions of sampling are observed to ensure representativeness and generalisability (e.g. random selection of subjects and random assignment to experimental or control groups). In contrast, the notion of theoretical sampling is used in the grounded theory approach (Strauss and Corbin, 1990). In theoretical sampling, participants are selected because they can illuminate the phenomenon being examined. This sample included differences in age, gender and illness severity, and contained participants who were currently receiving psychiatric treatment in hospital and participants currently receiving treatment in the community.

### **2.2.2 Inclusion Criteria**

Participants in each group met the following selection criteria:-

#### ***(i) The 'schizophrenic' group (S group)***

1. A current psychiatric diagnosis of schizophrenia (details of symptoms were recorded using the Manchester Scale; Krawiecka, Goldberg and Vaughan, 1977).
2. The presence of schizophrenic symptoms within the last six months.
3. Current level of depression is mild or below (defined by a score of 20 or below on the Beck Depression Inventory [BDI]; Beck, 1961).

#### ***(ii) The 'depressed' group (D group)***

1. Currently suffering from severe depression (defined by a score of 31 or above on the BDI).
2. The absence of schizophrenic symptoms (assessed on the Manchester Scale).

Two further selection criteria applied to both groups. First, participants who were judged by the recruiting clinicians to be significantly cognitively impaired or were suffering from a clear organic condition were excluded. Second, the study excluded potential participants if the recruiting clinicians, or the multi-disciplinary team, thought the participant would become overly distressed by the nature of the questions asked.

### **2.2.3 The Rating Scales**

#### **1) The Beck Depression Inventory (BDI; Beck, 1961)**

The BDI is a 21 item self report inventory which measures the current symptoms of depression. It is a well established scale and has high validity and reliability (Beck, 1961).

*ii) The Manchester Scale (Krawiecka, Goldberg and Vaughan, 1977)*

The Manchester Scale is designed to assess symptom severity in patients suffering from schizophrenia and covers the range of expected schizophrenic psychopathology (appendix 1). It contains nine items which are rated by a carer on a five point scale. Inter-rater reliability based on independent assessment of video-taped interviews was high (the coefficient of concordance ranged between 0.64 - 0.87 for reported symptoms and 0.58 - 0.73 for observed items).

**2.2.4 The Characteristics of the Participants**

Individual participant details are summarised in Tables 1 and 2. Participants were as closely matched as possible on age, illness duration, amount of present contact with services, employment (all were unemployed) and educational achievement (appendix 2). They were also closely matched on gender.

**Table 1. Participant details: Schizophrenia**

Participant	Age	Sex	Diagnosis	BDI Score	Duration of disorder	Contact with mental health services
1	39	F	PS	14	11 years	Day support
2	39	F	S	18	6 years	Day support
3	44	F	PS	12	8 years	Hospital
4	41	M	PS	8	22 years	Day support
5	47	M	S	16	30 years	Day support
6	26	M	PS	9	8 years	Day support
7	33	M	S	19	14 years	Once a week
8	49	M	PS	12	20 years	Day support

**Table 2. Participant details: Depression**

Participant	Age	Sex	Diagnosis	BDI Score	Duration of disorder	Contact with mental health services
1	58	F	MD	31	36 years	Day support
2	41	M	MD	41	10 years	Hospital
3	36	F	None	34	4 years	Once a week
4	64	M	MD	40	6 years	Day support
5	49	M	MD	33	20 years	Day support
6	50	F	MD	43	1 year	Day support
7	37	M	MD	30	12 years	Day support
8	62	F	MD	35	10 years	Day support

**Key**

PS - Paranoid schizophrenia

S - Schizophrenia

MD - Major unipolar depression

Details about the emotional difficulties or symptoms experienced by the participants are outlined in appendix 3.

## **2.3 The Measure**

### **2.3.1 Developing the interview schedule**

A semi-structured interview schedule (appendix 4) was generated which aimed to address the research questions. The development of the questionnaire was guided by an extensive review of the literature and by the author's preliminary ideas regarding issues of importance. It was deliberately left open ended in order to allow participants maximum freedom to express their own views and opinions. It also allowed for the development of new questions during the course of the research.

### **2.3.2 Piloting the interview schedule**

Minor changes were made to the interview schedule following a pilot study in which the interview was administered to two professional colleagues. The interview schedule was further piloted on the first participant from each group. Both were asked to comment on the interview and make recommendations regarding possible changes. As both participants thought they were able express themselves adequately and thought the interview needed no modifications, the interview schedule was not changed further.

### **2.3.3 Outline of the interview schedule**

A brief outline of the interview schedule is presented below. The interview was divided into eight sections. Questions were followed by a series of prompts which aimed to explore the questions in more depth.

#### ***Section 1: General information***

Details were sought about the participant's background information including their age, domestic circumstances, employment past and present, and educational history.



## ***Section 2: Past and current emotional difficulties***

Questions aimed to determine the emotional, practical and interpersonal difficulties the participant was currently experiencing, how and when the difficulties started and how the difficulties had changed over time. The questions also aimed to elicit the participant's explanations for these difficulties.

## ***Section 3: Current relationships***

This section explored the characteristics of the participant's current relationships with family, friends and mental health professionals. A series of subsequent questions explored the participant's feelings towards the family member, friend and professional to whom they felt closest.

## ***Section 4: Interpersonal problems***

This section aimed to elicit participants' views about what friends were for and how they made friends. It also asked participants about the difficulties they had in relating to others and their views about why this was difficult.

## ***Section 5: Past relationships***

This section explored participants' memories of their early relationships with family and friends. It also explored whether, and to what extent, the participant believed that their early experiences of relationships were having an impact on their present relationships and the types of interpersonal problems they experienced.

## ***Section 6: The relationship between mental illness and relationship difficulties***

Participants were questioned about their beliefs regarding the inter-relationship between their emotional difficulties and their current interpersonal problems.

## ***Section 7: The role of services***

Participants were asked how they would like to change their relationships with others. They were also asked about how services might be improved to help them make these changes.

### ***Section 8: Debriefing***

Participants were asked how they felt having completed the interview and whether taking part had raised difficulties. They were also asked whether there was anything which had not been covered. The author then read back the responses recorded during the interview. Participants were asked to comment on the accuracy of the notes and whether they wanted anything to be left out of the write up. The purpose of the research was reiterated and the participant asked whether they would be willing to meet again to comment on the emerging analysis. The participant was also asked whether they would like a summary of the study's findings.

### ***Section 9: Researcher's impressions***

After the interview the researcher recorded his impressions of the meeting and the feelings aroused in him by the participant.

## **2.4 Procedure**

### **2.4.1 Ethical Considerations**

A series of procedures were devised to ensure that (i) participants were able to make an informed choice about participation, (ii) participants who might find the interview overly distressing were not included in the study, and (iii) adequate support was available for participants should they become distressed during or after the interview. The research was designed so that it followed the British Psychological Society's Ethical Principles and Guidelines (1993) and the Division of Clinical Psychology Professional Practice Guidelines (1995). The research proposal was scrutinised and approved by two local research ethical committees (appendix 5).

#### ***(i) Briefing Procedures***

An information sheet (appendix 6) was developed which explained:

- (1) the nature and purpose of the research and what was expected of participants;
- (2) how confidentiality and anonymity would be addressed and;

(3) the participant's right to withdraw at any time and that this would in no way affect the care they received as a patient.

The information sheet was given to each participant by a professional involved in his/her care. The professional had been briefed by the author so that they could respond to any questions that the participant might have and so they could explain the purpose and nature of the study in a way the participant would understand. Participants were briefed again by the author during the preliminary meeting and at the start of each interview (using a standard briefing sheet; appendix 7) to ensure that they fully understood the three points listed above. They were encouraged to ask questions about the research at each stage.

***(ii) Establishing consent***

A standard consent form was devised (appendix 8). This was completed by the participant once the recruiting clinician was fully satisfied that the participant had made an informed decision about participation. The researcher also ensured that informed verbal consent was obtained in the preliminary meeting with each participant and before the main interview.

***(iii) The exclusion of participants likely to become overly distressed by the interview***

Each of the recruiting clinicians were fully informed about the nature of the study and the questions that would be asked. If the recruiting clinician was concerned that the interview might be distressing for a potential participant then he/she referred the matter to the multi-disciplinary team. People likely to become overly distressed by the questions were not approached.

***(iv) Safeguards should the interview have uncovered distress in the participants***

There was no expectation that the research would be distressing in and of itself, although the author was aware that the interview might uncover existing distress. The research therefore took place in a context where support could be provided to participants by people already involved in their care (e.g. in a residential home or day

care facility). The appropriate consultant psychiatrist was also informed about when each interview would take place and arrangements were made so that he could be contacted if necessary. All participants were debriefed after the interview. The author's work number was supplied so that each participant could make contact should any issues about the research emerge subsequent to the interview.

#### **2.4.2 Recruitment Procedure**

The researcher approached the consultant psychiatrists, clinical psychologists and team leaders in each of the community mental health teams or day centres from which participants were sought. Once their consent was obtained, the researcher met with members of the team, either individually or in groups, to explain the aims and rationale of the study. Individual participants were approached by a professional involved in their care. Once consent was obtained, the researcher set up a preliminary meeting in which the researcher helped the participant to complete the screening questionnaires. A time was arranged for the formal interview. The interview itself took approximately an hour and a half, with a ten minute break half way through. Responses given to the interview questions were recorded by hand and then fully transcribed onto computer later the same day.

#### **2.5 Data Management**

The interview transcripts were analysed individually using aspects of the grounded theory method (Strauss and Corbin, 1990). The grounded theory method aims to generate 'emergent' theory. In the methods outlined by Strauss and Corbin (1990) data collection and analysis are undertaken simultaneously so that emerging analysis further shapes data collection (Charmaz, 1995). Henwood and Pigeon (1995) describe this as 'ambitious'. Due to limited time and resources, analysis followed data collection in this study. Further theoretically driven sampling is required to build on the present analysis and to test the emerging theory.

The analytic sequence was as follows:

### ***1. Immersion***

Analysis started with a process of reading and re-reading the data to become familiar with the qualitative material.

### ***2. Coding***

Transcripts were then analysed by underlining meaningful segments of text, expressing a single coherent thought. These were abstracted from the transcript and labelled as basic codes. As further transcripts were analysed, the codes were gradually modified and extended and new codes developed. Segments of text unrelated to the research questions were discarded.

### ***3. Categorisation***

In the next stage of analysis, basic codes which appeared related to each other were grouped under more general headings. These groupings were then used to develop preliminary categories to describe the main features of the data. Each category was defined and then illustrated by selecting appropriate quotations from the transcript.

### ***4. Comparing the codes and categories generated by the two groups***

The codes and categories generated in each group were compared and contrasted.

### ***5. Thematic analysis***

Themes were identified across both groups by closely examining the emergent categories in each group and by looking for connections and differences between them. These themes were developed and explored through discussions with the author's supervisor.

### ***6. Respondent validity***

Two participants from each of the two groups were re-interviewed and were asked to comment on the emerging analysis (i.e. the codes, categories and themes generated within and between groups).

## **7. *Theory construction***

The last stage of analysis aimed to construct an emerging theoretical framework based on the interpretation of the categories and the themes generated from the data.

### **2.6 Reliability and Validity**

There is a long standing debate regarding scientific rigor in qualitative research. In quantitative research, scientific rigour is assessed according to the reliability (the apparent consistency and replicability of observations) and the validity (the generalised truth of statements) of the conclusions reached (Silverman, 1993). Some authors question whether such concepts are applicable to qualitative research given that no claims are made to 'objectivity' and multiple meanings are assumed (Bannister et al., 1994). Yet if we are to assume any stable properties in the social world (even if there are multiple ways of viewing such properties), and this assumption must be made if scientific research is to be of value, then issues of validity and reliability must be addressed (Stevenson and Cooper, 1997). This study employed several procedures to maximise both reliability and validity. These are outlined below.

#### **1. *Auditability***

Stevenson and Cooper (1997) have emphasised the importance in both quantitative and qualitative research of acknowledging one's biases and assumptions rather than hiding behind the mask of objectivity. A research diary (appendix 9) was kept throughout the study to provide a reflexive account of the research process. A detailed account of the procedures involved in the analysis has also been supplied. Together, they reveal the researcher's interpretative processes, subjective experiences and theoretical stance in relation to the analysis of the participants' transcripts and allow this process to be scrutinised by others. Erlandson, Harris, Skipper and Allen (1993) have termed this process the 'confirmability trail'.

### ***ii) Respondent validity***

In order to judge the validity of qualitative research it is important to determine the degree to which the findings represent participants' realities. Respondent validity provides a judgement regarding the quality of the researcher's interpretations (Silverman, 1993). In this study, respondent validity was obtained by feeding back the emerging analysis to two of the participants in each group.

### ***iii) Inter-rater reliability***

To assess the accuracy and generalisability of the researcher's analysis, an independent rater categorised selected examples of the text and placed them into one of the codes or categories previously generated by the researcher. Inter-rater agreement was calculated (Silverman, 1993). The results are presented in section 3.13.

### ***iv) Generativity***

The quality of a piece of research should be judged by its generative power and its implications for clinical practice and for further research (Henwood and Pigeon, 1995). The generative power of the study is evaluated in section 4.4.

### ***v) Rhetorical power***

The quality of qualitative research should also be judged by its rhetorical power. In other words, the extent to which others are persuaded by its results and conclusions. Rhetorical power was evaluated to some extent by examining participants' feedback on the emerging analysis (Henwood and Pigeon, 1995) and through comments made by other researchers in the field.

## **3. RESULTS**

### **3.1 Overview**

The initial analysis produced over 600 basic codes which were grouped under the relevant research questions. Through a continued analysis of the interviews these codes were modified and further grouped into emerging conceptual categories. This section begins by presenting an account of the emerging conceptual categories

generated for each research question. The conceptual categories for each group are briefly described and commonalities and differences explored. Exemplary quotations illustrate certain categories. The text refers to tables which list the categories generated for each research question and the numbers of participants who gave a response which could be included in each category. These tables (3-13) are presented in appendix 10. In the text each category, and associated quotes, are referred to and numbered in square brackets (these refer to the categories listed in the tables and do not refer to the number of participants who gave such responses). For a more detailed account of the codes subsumed under each category the reader is referred to appendix 11.

The results from the inter-rater reliability study and respondent validity study are then presented. The results move on to explore the themes which emerged from a thematic analysis of the data. The emerging theoretical framework is presented in the discussion. As outlined in the method, the group containing participants diagnosed with schizophrenia is labelled 'group S' and the group containing participants with depression is labelled 'group D.'

### **3.2 What friends are for**

Table 3 (appendix 10) illustrates those categories which emerged to describe participant's views about what friends were for.

#### ***(i) Common issues***

Both groups thought friends were for companionship [1]. Codes included 'sharing similar interests together' and 'preventing loneliness'.

*"They are people who appreciate the same things like music. It's someone to sit with and do those sorts of things with". [1]*

Closely linked to companionship was the idea that friends are to talk and share thoughts with [2]. Friends were also described as being people who provided emotional support [3]. Codes included under this latter category included people 'who you can talk to when you are low', 'who appreciate you' and 'who you can confide in'. Friends were also described as people you can have fun with [5].



## **(ii) Differences**

Practical support [4], such as the sharing of assets, was a more pertinent factor for the S group. One member of the D group expressed some bitterness and a belief that true friends no longer existed.

## **3.3 Ways of making friends**

Table 4 (appendix 10) illustrates the categories that emerged to describe participants' views about the way they made friends.

### **(i) Common issues**

Both groups reported making friends by joining clubs and societies [4] and reported difficulties because of the negative reactions (stigma) expressed towards them (and their mental health problems) by people in the general population [5a].

*"We were recently told that we couldn't sit on the steps outside. Why? Well just in case members of the public are intimidated when they walk through. I think that's dreadful don't you". [5a]*

### **(ii) Differences**

More S group participants reported having no difficulties making friends (despite appearing to have little close contact with people) or described very practical ways of making friends (e.g. by striking up a conversation) [3]. The D group gave more emotional reactions to the question. Many described no longer making active efforts to form friendships [2]. People were described as not being trustworthy [5e]. One participant thought that she gave vibes for people to stay away [5f].

*"Trouble is I give vibes to people that they should stay away. I think its because I'm too afraid of being rejected". [5d]*

It was interesting that both groups described avoiding other people with mental health problems. However, the rationale was different. For the S group it was because these people expressed too many needs or emotions [5b]. For the D group it was because these people could not be trusted [5d].

### **3.4 The interpersonal problems reported**

Table 5 (appendix 10) illustrates those categories which emerged to describe participants' views about the interpersonal problems they experienced.

#### **(i) Common issues**

Both groups experienced difficulties in forming relationships with people [2]. This ranged from problems in forming initial acquaintances to the development of intimate relationships. It was also not surprising given participants' responses to the previous question that both groups reported interpersonal difficulties that stemmed from the negative reactions of others [3] and that some reported feeling that they did not fit in with, nor felt accepted by, normal society [7].

*"People think we are nasty and don't want to know us but actually we are reasonably nice people".*

*[3]*

*"You have to be one of the crowd or else you are an outcast". [7]*

Two participants in each group reported that they would rather be alone [5].

#### **(ii) Differences**

There were clear differences in the way the two groups talked about their interpersonal difficulties. For the S group, having no interpersonal problems [1], or feeling that people got too close [4], were more pertinent issues. Also pertinent for this group was the negative effects that the physical, cognitive and paranoid symptoms of schizophrenia, and the side-effects of their medication, could have on their interpersonal relationships [8].

*"Because I shake so much people look at me and think I'm a loony, a head-banger, a woozy". [8]*

The D group talked more about the fact that other people took advantage of them [10], that they didn't believe people were trustworthy [11] and that there was a need to protect themselves against being hurt or rejected [12].

*"You just have to be really careful who you associate with. People just cannot be trusted you see; they are bound to let you down". [11]*

*"I'm going to have to back off .... If I let anyone near me they will hurt me. They would find out what I'm really like and they might not like it". [12]*

Other interpersonal problems reported by the D group included a tendency to be overly critical of people [13], low self esteem [15], a dislike of the social rules that govern relationships [16] and a feeling of helplessness at being unable to avoid the interpersonal difficulties that the participant experienced [14].

*"I don't really understand why people would want to know me. I'm ugly and my personality, well, there's nothing much there is there". [15]*

*"You see troubles always follow me. No matter what I do things always go wrong". [14]*

### **3.5 Explanations for the interpersonal problems experienced**

Table 6 (appendix 10) illustrates those categories which emerged to describe participants' explanations for the interpersonal problems they experienced.

#### **(i) Common issues**

Both groups thought their symptoms had a negative impact on their ability to relate to people [6]. One person in each group thought their interpersonal problems arose because they were not worthy of, or too unattractive to, form relationships with others [8].

#### **(ii) Differences**

The great majority of the S group thought their interpersonal problems were due to a lack of social skills [2]. In other words, people in this group wanted more relationships with people but thought they lacked the social skills that would enable them to do so. Codes included 'not knowing what to say to people', 'no longer knowing how to socialise' and 'not having the social skills or education to mix with people'.

*"It's like the conversation just drops". [2]*

*"Because I'm not educated properly I don't know how to talk to different classes of people". [2]*

This was a far less pertinent factor for D group participants. Their explanations for their interpersonal problems more often referred to the fact that they had experienced difficult relationships in the past [11] in which people had failed them or proved to be untrustworthy [10]. As a consequence, many were now wary of forming close relationships with others. Other people in this group thought that their interpersonal

difficulties were at least in part due to their inability to be assertive [5] and their fear of being rejected or hurt if they voiced their needs.

*"I suppose if I was more assertive I would be scared at people's reactions. If I rang up a friend and asked for something important then I suppose I would be scared they would put the phone down". [5]*

### **3.6 Past relationships with family and with friends at school**

Table 7 (appendix 10) illustrates the categories generated from participant descriptions of their early experiences with family and friends.

#### **(i) Common issues**

When describing difficult aspects of their upbringing some participants in both groups thought they had experienced little personal control in their family [2a]. Codes included 'a cold and domineering father', 'mother extremely possessive' and 'a strict upbringing'. Participants from within both groups also described feeling alone in the family [2b] and being lonely at school [3c].

#### **(ii) Differences**

S group participants were much more likely to give positive comments about their early family experiences [1], and were more likely to give negative comments about their early experiences with friends at school [3], than D group participants where the relationship was reversed. They were also much more likely to describe having been teased or bullied at school [3a]. In contrast, members of the D group reported experiencing little emotional contact [2d] or negative emotional contact [2e] from family members. Some also expressed anger at the way they had been treated as children [2f].

*"I think I crave affection because I never got it off my mum. I can still feel like a vulnerable child. Dad could be nice when he was around". [2d]*

*"Mum could be really nasty to me. That hasn't healed. You can't heal things like that in the way a bruise or broken arm can heal. She was just a source of continual criticism". [2e]*

### **3.7 How the onset of the participants' emotional difficulties impacted on their relationships**

Table 8 (appendix 10) illustrates the categories generated for participants' responses to this question.

#### **(i) Common issues**

Both groups reported increased loneliness as a result of their emotional difficulties [1]. Participants reported that they were not understood by others, that they could no longer cope with society and that they avoided people either out of fear or because of the personal shame they experienced. One participant from each group also talked about the resentment they experienced from others [3] because they were no longer able to cope.

*"I felt so worried that people would attack me that I just stayed inside all day. I just slept". [1]*

#### **(ii) Differences**

S group participants expressed more resentment at others. Some thought people "had treated me like shit" and one reported being forced to leave home [2]. D group participants talked more about the personal shame they experienced at the beginning of their emotional difficulties and their resulting efforts to withdraw from people and their attempts to cover it up [4].

*"I avoided people because I did not want them to see me like I was". [4]*

### **3.8 Describing current relationships in the family**

Table 9 (appendix 10) illustrates the categories generated when participants were asked to describe their current relationship with their family and details about their relationship with the family member to whom they were closest.

#### **(i) Common issues**

Participants in both groups made positive comments about the person in the family they were closest to (e.g. "it's nice" or "it's good"; 11). People enjoyed talking to this person [7] and at least one person in each group reported gaining emotional support [17] or practical support from them [18].

*"He tries hard to understand and support me when I'm down". [17]*

*"She helps me financially". [18]*

## **(ii) Differences**

More S group participants reported having a close family [1] and all were in contact with at least some members. The only salient negative comment made by some S group participants was that some members of the family expressed negative or hostile feelings towards them [2]. They had a clear tendency to talk about their closest family member in more practical and less emotional ways [25]. They were far more likely to describe practical activities they undertook with them (such as shopping), give practical descriptions of the person [11] and talk about the practical types of support they received from them [16].

*"She's got brilliant taste you see and an immaculate home". [11]*

*"She deals with my cheques and bank details and things". [16]*

They made fewer negative comments about the person [18], and if they did it was about not being given enough independence [19], and more often said they were satisfied with the amount of support they received [23].

*"I suppose it's that she treats me like a child. Sometimes she tries to take over my life". [19]*

If they were not satisfied they more often gave external, practical reasons for it [24a].

*"She does not have enough money to see me more". [24a]*

*"She works five days a week you see so she can't see me more". [24a]*

More D group participants reported difficulties in relating to their families such as feeling shameful [3] and not feeling understood by them [4].

*"When I came out and then later told them I was an alcoholic, I think my parents felt it was a big slur on the family. I just feel a complete failure". [3]*

*"The family feel I should just be able to cope and get on with things". [4]*

Two D group members had no contact with any family members [5]. Those that did expressed some positive emotions towards their closest family member [13] and described the emotional support they received [17].

*"He's always there and that's nice. He can make me feel like a little child - all safe so that nothing can hurt me". [17]*

However, they also made more negative comments about this person than S group participants. These included not receiving enough support [21 and 24] and losing self-esteem when with them [22].

*"It's as if he has finally beaten me, which in a sense he has. He's got the things that make people happy". [22]*

Whilst they also gave practical reasons for this being so [24a], some also placed the 'fault' with either the family member [24b] or with themselves [24c].

*"I just can't seem to find the energy to maintain contact". [24c]*

### **3.9 Describing current relationships with friends**

Table 10 (appendix 10) illustrates the categories generated when participants were asked to describe their current relationships with friends and details about their closest friendship.

#### **(i) Common issues**

When describing their closest friendship participants from both groups felt positive about being with that person [15] although one participant in each group also reported feeling inferior to them [16]. Both groups thought emotional support [18] and having a laugh [21] were important in their relationship.

*"I write to her when I'm up and when I'm down. She is all purpose like a J-cloth. although I would never put her in a washing machine". [18]*

Some members of both groups also talked about having difficulties in coping with the friend's mental health problems [24] and some thought the relationship was one-sided [25].

*"She claims that someone else has got her real children. It's difficult being with her when she's like that". [24]*

*"He scrounges off me all the time". [25]*

#### **(ii) Differences**

Whilst all S group participants reported at least one friendship, the majority were suspicious of people taking advantage of them [1]. Perhaps because of these feelings, two participants thought that it was best to remain apart from people [2].

*"It's like, well friends are always on the tap here. They are always scrounging, always want money". [1]*

The closest friends of S group participants were more likely to also be receiving psychiatric treatment [12] than the closest friends of people in the D group [11 and 13]. The S group generally had more contact with these friends and, perhaps as a result, were also more likely to gain companionship [19] and practical support [20] from them.

S group participants were more likely to feel satisfied with the support they received from friends [28]. One participant thought more support would be suffocating. When they were not satisfied they tended (as when talking about their family) to give external, practical reasons for the discrepancy [29a].

*"She is a single mum you see". [29a]*

In contrast, three members of the D group reported having no friends at all [6]. One member did not feel worthy enough to have friends [7] and another talked about the difficulties he experienced in maintaining friendships [10].

*"People at AA tell me they are my friends but I don't really believe them. There's no reason why they would want to be, is there". [7]*

*"I find it difficult to write to people. When I get low I can't do as much. What's the point, everything I write is going to be crap". [10]*

D group participants were also more likely to be dissatisfied with the amount of support received [29]. Two participants were fearful of leaning too much on the person [29b] in case the friend decided to withdraw from them as a result. Given that D group participants were more likely to report friends from outside mental health services it was not surprising that two members thought that the friend sometimes dominated the relationship and that being with them sometimes resulted in reduced self-esteem [26].

*"She ignores me sometimes and that can make me feel really stupid". [26]*



### **3.10 Describing current relationships with mental health professionals**

Table 11 (appendix 10) illustrates the categories generated when participants were asked to describe their current relationships with professionals and details about their relationship with the professional to whom they felt closest.

#### **(i) Common issues**

When describing their relationship with the professional to whom they were closest, participants from both groups talked about the emotional support they received [9].

*“She really supports me, like a conductor who by knowing the music can bring it out properly”. [9]*

#### **(ii) Differences**

Many more D group participants than S group participants reported having no close contact with any professionals [3] and they were more likely to give negative comments about professionals in general [2]. These negative comments included not feeling close to staff [2a], not receiving enough support from staff [2b], feeling that staff were not really interested in patients [2c], that support was difficult to access [2d], that services tended to smother the participant [2e] and that staff should be provided with more extensive training [2f].

*“If you see a psychiatrist say then all you get at the end is ‘see you in three weeks time and I hope you do OK’. They couldn’t care less really and they then just bring the next one in”. [2c]*

*“Staff do not approach you you see, and when you are low it’s not easy to approach them yourself”. [2d]*

*“It’s safe but it also holds, contains and traps. It has limited expectations of you. It is too gentle, it doesn’t push you”. [2e]*

They were also more likely to state that they did not receive enough support from the professional closest to them [18].

S group participants were generally more positive about their relationships with professionals [1] and their relationship with the professional to whom they were closest. They were also more likely to report being satisfied with the amount of support they received [17].

### **3.11 The inter-relationship between the participants' emotional difficulties and their relationships with others**

Table 12 (appendix 10) illustrates the categories generated from participants' responses to three questions. The first question aimed to tap participants' explanations about the cause or origin of their emotional difficulties. The second asked to what extent the participants thought that relationship difficulties had contributed to their emotional problems or symptoms. The third asked whether their emotional problems or symptoms had changed their relationships with other people (either in a positive or negative way).

#### **(i) Common themes**

Whilst S group participants gave more 'biological' explanations for their emotional difficulties, some described the impact of life events. One participant in each group talked about the impact of work stress [5a<sup>ii</sup>]. Others talked about the impact of loneliness [5b<sup>i</sup>] and a violent attack on themselves or a member of their family [5b<sup>iii</sup>].

*"I didn't say hello to anyone for about three years". [5b<sup>i</sup>]*

Participants in both groups talked about the negative effects of their symptoms on their relationships with other people [16a] and the negative reactions experienced from others as a result of their mental health difficulties [13 and 16b].

*"I lose concentration when I get depressed and then I just can't talk to people". [16a]  
"When I have the voices I don't feel normal. I feel so bad then that I just can't talk to people". [16a]*

#### **(ii) Differences**

S group participants more often gave biological [1] or 'in the mind' [5] explanations for their emotional difficulties or symptoms and were less likely to describe the impact of simultaneous life stressors [2].

*"It's inner speech that comes from not thinking properly. If I was mentally stronger then I wouldn't get the voices". [5]*

If an S group participant believed that a personal event had contributed to their emotional difficulties, they were likely to talk about it in a more detached, practical way. It was more often about difficulties in *forming* relationships (rather than

experiences of negative relationships or loss) and their inability to obtain a partner [5bii and 7].

*“It was really difficult to get a girlfriend you see. I just didn’t know how”. [7]*

Two S group participants also reported that their emotional difficulties became worse when they had too much contact with others [9] or when others were displaying too much negative affect or emotion [10].

*“If there are too many people around the voices start you see”. [9]*

The D group talked more about the impact of personal events and when asked specifically, about the impact of relationship difficulties. These included emotional neglect in early life [5bv and 12b], a lack of personal control (particularly in their early family life - 5bvi and 12a) and the loss of people close to them [5bvii and 14].

*“I never received praise or affection and it means I’ve felt ugly and useless since”. [12b]*  
*“You see I had never learnt to stand on my own; my mother had done everything for me”. [12a]*

A further important difference between the two groups was illustrated by participants’ beliefs about how their emotional difficulties or symptoms had impacted on their relationships with others. Whilst there were common negative experiences described in the previous section, four S group participants described having much more social contact as a result of being in mental health services [17a]. This was not pertinent for D group participants. This group talked more about the social withdrawal [16d] and feelings of stupidity [16e] that accompanied their symptoms and one participant described being smothered and stuck in mental health services [16f] with the result that he no longer felt able to form relationships with people in the general community.

*“It’s like a ghetto, you are safe in it but you can’t break out of it. Almost everyone I know now is in them”. [16f]*

Two D group participants thought they had never formed a ‘real’ relationship [15].

### **3.12 Desired changes and the role of mental health services**

Table 13 (appendix 10) illustrates the categories generated to participants’ responses about how they would like their relationships to be different and about how services

could be changed or modified to meet their needs (particularly their social needs) more adequately.

### **(i) Common issues**

There were surprisingly few common issues in the two groups when participants were asked how they would like their relationships with others to be different. More common themes emerged when participants were asked how services could be changed or modified to meet their social needs. Such changes included more contact or support from staff [16], more contact with specific professionals such as community psychiatric nurses [17] and more organised social activities [19].

*“It could be different here if the keyworkers had regular chats with you. Nine times out of ten when you are in a crisis then they are not there”. [16]*

### **(ii) Differences**

When asked about how they would like their relationships with others to be different, S group participants talked about desiring *more* relationships with others [4] and an ability to be more sociable [3]. Many believed these changes would occur if they no longer experienced the symptoms of their illness [2].

*“People know I’m a cretin just by looking at me, my dress, my speech, how I walk and that. People can see that I’ve got problems”. [2]*

D group participants more often expressed a desire to form *closer* relationships with others [6] and wanted to change specific aspects in themselves, such as being able to trust people more, which prevented them from doing so [8]. Two wished they could change their childhood experiences with their family [10].

*“I would really want someone who loves and understands me”. [6]*

One D group participant wanted to eliminate the shame she felt by moving to a different area of the country and re-inventing herself. Another wished he would receive no more abuse from strangers [12]. Two participants thought their relationships would be better if they had a job or goals in life [13].

There were also differences between the groups in the way they thought services could be changed or modified to better meet their needs. D group participants were less satisfied with current services [14] and more often felt disillusioned with the care they received [15]. Two talked about their frustration at being unable to form *real* relationships with staff [16].

*“Mental health services can feel like a mirage, the relationships often do not seem to be real. It’s a false atmosphere, staff relate because it is their job not because they are interested in me”. [16]*

They also expressed a much clearer desire for services to be better organised so that a more constructive, planned approach could be taken with patients [23].

*“Some people are very happy not to leave mental health services. I’m not but there is no recognition that that is the case. I can’t do it all on my own. Staff need to communicate much better with each other and plan a co-ordinated approach to someone’s life”. [23]*  
*“I think people are just left to drift for too long. They are basically herded like cattle. You must keep on at people and not allow them to drift away”. [23]*

The only organisational issue expressed by S group participants was a desire for services to be less crowded [22].

### **3.13 The results of the inter-rater reliability study** (appendix 12)

An independent rater sorted segments of text from four interviews (two from each group) into the basic codes generated by the researcher in response to two of the research questions (participants’ explanations for their interpersonal difficulties and the impact relationship difficulties had on their emotional difficulties or symptoms). Percentage agreement on code assignment with the author was calculated for each research question. Table 14 shows high inter-rater reliability.

**Table 14. Results of inter-rater reliability for basic codes**

Research question in which codes were contained	Percentage agreement for the S group	Percentage agreement for the D group
Participants’ explanations for their interpersonal difficulties	84%	80%
The impact of relationship difficulties on participants’ emotional difficulties or symptoms	88%	86%

The independent rater also sorted segments of text into the categories originally generated by the researcher for each of the research questions. Percentage agreement

on category assignment was also calculated. Table 15 shows good inter-rater reliability across all interviews.

**Table 15. Results of inter-rater reliability for the categories generated**

Research question in which the categories were contained	Percentage agreement for the S group	Percentage agreement for the D group
Participants' explanations for their interpersonal difficulties	78%	76%
The impact of relationship difficulties on participants' emotional difficulties or symptoms	82%	80%

The limitations of this study are discussed in section 4.4.

### **3.14 Results from the respondent validity study**

A questionnaire was generated for each group which contained detailed summaries of the categories generated from the original interviews (appendix 13). Two participants in each group were re-interviewed and asked whether the account accurately reflected their experiences. A summary of the findings is presented in appendix 14. In general, the categories appeared to accurately reflect the participants' experiences. Participants were also asked to comment on the themes generated in the research and were asked specific questions which related to the theoretical framework generated. These results are presented in the discussion.

### **3.15 The Thematic Analysis**

The themes generated from the data are presented below. Some themes are common to both groups. Others describe what appear to be important differences between them.

#### **Loneliness and isolation**

Participants in both groups described difficulties in forming relationships with others. Most felt lonely and isolated. For many, this isolation existed in early childhood and at school (i.e. before the onset of symptoms), although it increased once their symptoms began. Some reported that their interpersonal difficulties were so severe that they would rather be alone.

### **The negative reactions (stigma) from others**

Both groups reported interpersonal difficulties that stemmed from the negative reactions (and stigma) expressed towards them (and their mental health problems) by people in the general population. For many this resulted in either anger and resentment (particularly for S group participants) or low self esteem and personal shame (particularly for D group participants). Some D group participants thought that the prejudice left them feeling trapped in mental health services. Participants in both groups reported that they now tended to avoid, and felt alienated from, people in the general community.

### **Home and school**

The majority of S group participants described their early experiences in their family in positive ways, although two described having a lack of personal control and one of these also described feeling alone. In contrast, the majority of this group reported being lonely at school. Many were teased or bullied.

The pattern was reversed for D group participants. They were more likely to make negative comments about their early experiences with their family and more often reported feeling lonely in it. Many experienced little or negative emotional contact from family members and more talked about having little personal control. Some expressed anger at their experiences. In contrast, while some D group participants reported feeling lonely at school, they more often reported positive experiences with childhood peers than members of the S group.

### **An emotional versus a practical focus towards relationships**

Participants in both groups thought emotional support was an important component gained from their relationships. Yet S group participants very rarely gave emotional responses, or described the influence of emotional factors, in their responses to any of the other questions. S group participants were much more likely to stress the importance of practical support in friendships, such as the sharing of assets, than D group participants. They more often talked about practical ways of making friends

(i.e. through conversation) and some even expressed a desire to avoid other people who expressed too many emotions. They were more likely to report no interpersonal difficulties (despite appearing to have little close contact with people) or describe issues that arose when people became too close to them or when they lacked independence from the family. Their explanation for their interpersonal problems often centred around a lack of social skills. In other words, whilst they expressed a desire to form more relationships with people, they thought they lacked the practical skills to do so. The researcher also found it difficult to establish any deep emotional contact with any S group participant. Overall, they talked much less about the emotional contact they experienced with others and they expressed few desires to form closer, more emotional ties with other people.

Much greater emphasis was placed on emotional support (particularly that received by friends) by D group participants. This group were also more likely to comment on a perceived lack of emotional contact in their relationships. They were more likely to emphasise the role that emotional neglect in early life had on the development of their depression. It was interesting that the researcher found it easier to establish emotional contact and rapport with this group.

### *Awareness of intimacy*

S group participants were more likely to talk about their inability to *form* relationships with others. Difficulties in forming *intimate* relationships, or difficulties associated with a betrayal of intimacy, were not pertinent issues for this group. In fact some S group participants thought their symptoms worsened when other people displayed negative affect or 'excessive' emotion.

Whilst D group participants often desired more intimacy they also made few active efforts to make friends. Their rationale was usually associated with the fear that this intimacy would be abused or betrayed. Not surprisingly, their interpersonal problems were often associated with a fear of being taken advantage of, a belief that other people were untrustworthy and because of a perceived need to protect themselves from being hurt or rejected. Many described difficult past relationships in which



people had proved to be untrustworthy. Many received little or negative emotional contact from their parents. Some participants expressed deep anger at the fact that this had been so. Overall, this group appeared to yearn for more intimacy with others whilst remaining fearful that the closeness could be betrayed.

### **Differences in social comparison**

D group participants tended to compare themselves to, and the adequacy of their relationships with, people in the general population. Only two D group participants (compared to six in the S group) reported a closest friend who was also currently receiving mental health treatment. This was despite the fact that participants had a similar amount of contact with day support facilities. Perhaps as a result of making these social comparisons, D group participants more often reported having no friends (despite attending day support facilities) or more often reported feeling inferior to them (with a subsequent negative effect on their self-esteem). It may also account for why they more often reported having one-sided relationships in which they contributed more to the friendship than the other person.

S group participants made more comparisons with people who were also currently receiving mental health treatment. As a result, they were less likely to feel inferior in the relationship, they were likely to see their friends more, and they gained more companionship and practical support from them.

### **Relationship needs**

S group participants talked about desiring *more* relationships with others and several wanted to increase their ability to be sociable. Most reported being satisfied with services although two wished services were less crowded (and therefore perhaps less intimate). Many described the increased number of friends they had through contact with mental health services. This was not a pertinent factor for the D group.

In contrast, D group participants more often expressed a desire for *closer* relationships and wanted to change specific aspects of themselves, such as being able to trust people more, which prevented them from doing so. This group were also more likely to be

disillusioned with the current services they received. Participants talked about their frustrations at being unable to form *real* relationships with staff and being 'trapped' in mental health services without a constructive approach to help them return to general society.

## **4. DISCUSSION**

### **4.1 Outline**

The discussion begins by proposing a tentative theoretical framework to explain the participants' responses to the research questions. The theory is grounded in the data and themes presented in the results. The discussion goes on to provide a summary of the theory developed, in which existing theory is incorporated and contrasted. The reliability and validity of the research findings are then evaluated. A critique of the research is made and clinical implications for service delivery discussed.

Recommendations are also made for future research.

### **4.2 A Developmental Theoretical Framework**

The emerging theoretical framework developed for each group is presented below.

#### ***(i) A developmental framework for participants in the S group***

##### **Early experiences**

As explored in the 'Home and School' section of the results, the majority of S group participants described their early family experiences in positive ways. In contrast, they more often reported negative experiences at school, particularly experiences of being bullied or teased (the relationship was reversed for the D group). What might explain such a difference?

##### **An inability to reflect on one's own mental states or the mental states of others**

One of the important themes that emerged was the difference between the groups in their tendency to exhibit an emotional versus a practical focus towards relationships. S group participants talked little about the emotional contact they experienced with others, they placed more emphasis on practical support such as the sharing of assets, and they expressed few desires to form close, emotional ties with other people. It is

hypothesised that this, together with other features of the data, occurred because the S group had more difficulty perceiving and understanding themselves and others in terms of emotions or mental states (feelings, beliefs, intentions and desires). The ability to reflect on one's own or other's mental states requires a capacity to distinguish between inner and outer reality and pretend from 'real' modes of functioning. Piaget (1952) described this as 'a theory of mind', Main (1991) described it as 'metacognitive monitoring', and Fonagy, Steele, Steele and Target (1997) as a 'reflective-functioning' ability. It is an ability which is usually developed in the first few years of life, and according to Fonagy et al. (1997) depends upon the caregiver's capacity to reflect accurately on the mental states of the child.

Why would the S group participants have more limited 'reflective-functioning' abilities? Several tentative hypotheses suggest themselves. It may be a result of inconsistencies in early parenting, in particular, the parents' failure to reflect appropriately and consistently on the mental state of the child. Alternatively, it may have had a defensive function in early childhood and protected the child's developing ego from deficiencies in early parenting. Whilst it may protect the person in childhood, it may then become a characteristic response to all subsequent intimate relationships. When considering issues of blame, both will be unpopular hypotheses (Johnstone, 1993). Little support for either was generated from the responses given by the participants themselves. However, this is not surprising if they do have difficulties describing their problems in this way. A clue might lie in the descriptions some participants gave regarding having little personal control in early life. Perhaps a dominant and intrusive early parenting style led participants to protect or defend themselves against the pain that would arise if they were to understand the emotional content of their parents' minds. An alternative, less controversial hypothesis is that this inability reflects an innate cognitive or biological disability. These issues are discussed more fully in section 4.3.

The S group's 'reflective-functioning' difficulties did not appear to disrupt their early family relationships. However one hypothesis (and there was some evidence to support this) is that the effects were more pronounced when participants began relating

to childhood peers. An inability to accurately reflect on the mental states of others is likely to be a severe handicap when forming relationships in childhood. Certainly, S group participants reported more active rejection from peers. They more often reported being teased or bullied than D group participants whose reflective functioning ability may have been more developed. There is independent evidence that mentalising capacity is related to the quality of childhood relationships (Beeghly and Cicchetti, 1994).

It was interesting that when S group participants described their interpersonal difficulties, the great majority thought these stemmed from a lack of social skills. As outlined in the introduction, early relationships with peers may be crucial for the development of social skills and competencies. For example, in childhood, friends are more likely than family to emphasise the need for reciprocity and obligation. A difficulty in reflecting on the mental states of childhood peers, and the active rejection that may result from it, may have severely hampered this group's ability to learn the social rules and competencies required for effective peer functioning.

### *Current relationships*

Both groups of participants reported feeling lonely and isolated. A partial explanation for both was the stigma, rejection and resulting isolation from people in the general community. However, a difficulty in 'reflective-functioning' may result in the relationship characteristics specific to the S group. S group participants were more likely to stress the importance of practical support in friendships, they were more likely to talk about practical ways of making friends and some avoided people expressing too many needs or emotions. When describing their contact with their closest family member they were likely to give practical descriptions of the person and talk about practical support received. They were also more likely to report having no interpersonal difficulties (despite appearing to have little close contact with people) or describe issues that arose when people got too close.

These relationship characteristics are not surprising if this group have difficulties in 'reflective-functioning'. It would be difficult to be with people who express too many

emotions if the emotions are incomprehensible to the participant. It was particularly interesting that when this group expressed dissatisfaction with the support they received, they almost always gave practical, non-emotional explanations for it. It was also revealing that the researcher found it difficult to form close emotional contact with S group participants during the interviews.

### *Social comparison*

S group participants more often described having friends who were also receiving psychiatric treatment. It is possible to speculate that difficulties in 'reflective-functioning' result in a less severe handicap when forming relationships with people with similar reflective difficulties. It may be easier to form complementary relationships with this group (Horowitz, Rosenberg and Bartholomew, 1993), poor social skills may be more accepted, and contact is less likely to reduce a participant's self-esteem. In many ways these results fit the predictions of social comparison theory (Brewin and Furnham, 1986). For many, services appeared to provide a context in which this group felt, for the first time, accepted by (rather than rejected by) a group of peers.

### *Relationship needs*

When describing how they would like their relationships to be different, S group participants talked about desiring *more* relationships and an increased ability to be sociable. Again, difficulties in 'reflective-functioning' are relevant here. No member of this group expressed a desire for more intimate relationships, in fact some thought that current services were too crowded (and perhaps too intimate).

### *Explanations given for their emotional difficulties or symptoms*

Again, if we hypothesise that the participants in the S group had difficulties in 'reflective-functioning', it was not surprising that this group gave more biological explanations for their mental health problems and were less likely to describe the impact of personal events. Alternatively, they may not have the 'discourse' to explain things in this way (see below).

*The interaction between difficulties in 'reflective-functioning' and the discourse available to explain or describe interpersonal problems or mental health difficulties*

Thus far it has been hypothesised that the tendency for S group participants to give biological or cognitive explanations for their symptoms, and practical explanations for their interpersonal difficulties (i.e. a deficit in social skills), lies in this group's difficulties in 'reflective-functioning'. However it is also possible that these difficulties reflect, and in turn impact on, the restricted social discourse available to this group.

During this research several health professionals questioned the value of conducting research on relationships with people with schizophrenia. Perhaps this was because the research did not fit the prevalent social discourse currently available for explaining the symptoms of schizophrenia. The current discourse is generally limited to biological and neuroanatomical considerations with drugs being the treatment of choice. Given this current discourse it is perhaps not surprising that participants with schizophrenia were also likely to explain their symptoms in this way. In contrast, the societal discourse available to explain the symptoms of depression is broader, and includes social and psychological components. Perhaps because of the availability of this discourse, people with depression were more likely to describe the impact of personal events on the aetiology and course of their depression.

It was also interesting that professionals expressed concern that the S group might become overly distressed because of the personal nature of the interview and, as a result, it was difficult to obtain ethical approval (see research diary; appendix 9). In reality, no S group participants became distressed. In fact far more emotion was expressed by D group participants. This raises an important issue. Perhaps, at some level, professionals were acknowledging this group's desire to avoid intimate contact with others and acknowledging the defensive function this might have. Perhaps there was concern that the personal content of the interviews might disrupt such a defence.

It is also possible to take this theory a step further although this moves beyond the data generated in the study. Perhaps the societal discourse itself acts to protect this group from more intimate and emotional contact. If the explanation for the aetiology of

'schizophrenia' is a 'medical' one, then this group's difficulties in reflecting on the mental states of others will remain unchallenged. The societal discourse would be serving to protect and reinforce the defence.

***(ii) A developmental framework for participants in the D group***

**Early experiences and the formation of attachment models**

D group participants were more likely than S group participants to reflect on their own mental states, and the mental states of family members, in early life. Many thought they had received little care or attention. Others talked about having little power, control or autonomy. Many thought these experiences had impacted directly on their current depression. It appeared that most had formed negative internal working models of care-giving relationships.

D group participants also reported less active rejection by peers in childhood. It is hypothesised that this was because they were better able to reflect on the mental processes of others which, in turn, enabled them to learn more social skills, and learn more about social rules and conventions, than was possible for S group participants.

**Current relationships**

The stigma placed on the D group by society, and the subsequent rejection they experienced, clearly impacted on their ability to form relationships with people outside mental health services. However, it is also hypothesised that these difficulties were exacerbated by their negative internal working models of caring relationships. This group appeared more wary of relationships in general. They were more likely to describe negative aspects of particular relationships and to have given up making active efforts to form friendships. They avoided people (especially people with mental health problems) because they could not be trusted. It appeared that their early relationships had resulted in a continued anticipation of betrayal or rejection. They desired intimacy, and often made emotional contact with the researcher, yet were fearful of the hurt or rejection that might result.

### *Social comparison*

D group participants were more likely to report having friends in, and to compare themselves to, people in the general population. As a consequence of such comparisons, they often reported feeling inferior to their closest friends and suffered from reduced self-esteem when with them. For some participants this sense of inferiority led to feelings of shame, feelings which in turn reinforced a participant's decision to avoid others. Despite these difficulties, D group participants did not tend to compare themselves to other people with mental health difficulties (unlike S group participants). Yet such social comparisons would not be directly predicted by social comparison theory (Brewin and Furnham, 1986) which suggests people compare themselves to others with a similar rank. Perhaps this was because of the intimate and 'real' contact such relationships (and hence social comparisons) could provide.

### *Relationship needs*

D group participants more often described desiring closer, more intimate relationships with others and expressed a desire to change aspects of themselves, such as trusting people more, which prevented them from doing so. They were more negative about mental health services, complaining that the relationships they formed in them were not 'real'. Some felt trapped in services. There appeared to be a vicious cycle operating here. The more support a person received from services, the more passive, submissive and helpless they felt. Whilst they felt safe, their passive stance resulted in a reduced self image and increased depression. Finally, the more depressed they became, the more they had to rely on services and felt unable to interact with the outside world. Some D group members wanted to form goals in life. For some this meant returning to work.

### *Explanations for their emotional difficulties or symptoms*

The D group were much more likely to describe the impact of interpersonal difficulties on their symptoms than the S group. This may be because depression is affected more by interpersonal difficulties than schizophrenia. Alternatively, it may be because this group found it easier to reflect on their own and others' mental states. Finally, it may



be because this form of discourse is more available to people suffering from depression.

#### **4.3 Summary**

In the previous section a tentative theoretical framework was introduced which aimed to account for participants' responses to the research questions. The aim of this section is to further evaluate the theory using research data and theoretical developments from other areas.

#### **Schizophrenia**

It was hypothesised that difficulties in 'reflective-functioning' had an enormous impact on S group participants. It appeared to impact on the way they described and made sense of their past relationships. It appeared to influence their ability to form relationships with others and the type of support they desired. Yet why do this group find it difficult to reflect on mental states?

Bateson et al. (1956) argued, in their double bind hypothesis, that families containing schizophrenic members often exhibit deviant, internally-inconsistent communication patterns. More recently, Lidz (1993) has argued that the intrapsychic chaos that characterises schizophrenia reflects a chaos-inducing early family environment and a 'milieu filled with inconsistencies, contradictory meanings and the denial of what should be obvious'. Tentative empirical support has been obtained which suggests these families do exhibit unusual and sometimes contradictory patterns of communication (Leff, 1982). It is possible that this inconsistent and contradictory communication (e.g. involving verbal messages which contradict non-verbal signals) results in a child being unable to accurately reflect on the mental states of those giving such communications. If this inconsistent communication characterises a child's early experience with caretakers then they may not learn the skills necessary for competent 'reflective-functioning'.

It is also possible that the inability to reflect on mental states serves a defensive function. It may protect a child's ego from being 'destroyed' in the face of otherwise

incomprehensible and inconsistent communication. This may be particularly important in families where caretakers exhibit controlling and dominant patterns of communication that threaten a child's ability to form a sense of self.

Such a hypothesis would fit with current ideas from both cognitive and psychodynamic traditions regarding the defensive functions of the symptoms of schizophrenia. To illustrate, I will briefly review Chadwick et al.'s (1996) theory regarding the defensive function of the symptoms of paranoia. They argue that certain forms of paranoia persist because they defend against low self esteem and a fragile sense of self. The fragile sense of self is hypothesised to arise because of absent, inconsistent or dominant parental representation in early childhood. If a parent is absent or severely neglectful then a child may lack the attentive, 'objectifying' or 'mirroring' other that is necessary to form an objective self that is distinct from other aspects of a child's internal world. Alternatively, if a parent is excessively present and intrusive, there is a danger that the self will be possessed or even destroyed by the other. They suggest that either parental style results in a fragile sense of self. Paranoia is hypothesised to defend against this fragile self. They argue that forming a belief that others are out to persecute you defends against a sense of being ignored, neglected and insignificant, with associated feelings of emptiness and despair. The inability to reflect on the mental states of others may also serve a similar protective function.

Another alternative hypothesis is that the inability to reflect on mental states reflects an innate disability in a child's cognitive abilities. The cognitive processes required to develop a 'theory of mind' or reflect on the mental states of others have been outlined by authors such as Piaget (1952) and Harris (1989). This disability may be inherited or it may reflect an underlying vulnerability factor (Clements and Turpin, 1992) in 'schizophrenia'.

Whatever the cause, difficulties in 'reflective-functioning' potentially leaves a person suffering from schizophrenia in a precarious position for this is the very ability that is required to distinguish between inner thoughts and outer reality and between real events and pretend or make believe. It would account for the deficits in reality testing

outlined by authors such as Frosch (1986) and Bentall (1993). In other words, difficulties in 'reflective-functioning' may not only account for the relationship patterns these participants described, but also partially account for, or be associated with, the symptoms (e.g. visual and verbal hallucinations, delusions and paranoia) they experienced.

It is important to return to the primary focus of this research and explore some of the ways in which difficulties in 'reflective-functioning' will affect a person's ability to form relationships with others and to utilise the social support potentially gained from them. The results of this research suggest that people suffering from schizophrenia are less likely than people suffering from depression to value emotional or intimate contact with others. In some cases close emotional contact was described as aversive. If we hypothesise that difficulties in 'reflective-functioning' have a defensive function then too much emotional contact is likely to be aversive because it threatens the defence. This would fit with Hirschberg's (1985) suggestion that social isolation may protect this group from excessive (and incomprehensible) social stimulation and prevent them from being overwhelmed rather than supported by their connections. It would also explain why this group suffer an increased likelihood of relapse after returning from hospital when they experience high levels of 'Expressed Emotion' in their family (Lam, 1991) given that much of this emotion is likely to be incomprehensible. It is also not surprising that participants in this group expressed a desire for more, but not closer, relationships with others. It may also explain this group's tendency to explain their interpersonal difficulties as being a result of inadequate social skills. If this group find it difficult to reflect on the mental states of others then they will find it particularly difficult to learn or employ the social rules that govern relationships.

### Depression

In contrast to S group participants, D group participants appeared to find it less difficult to reflect on their own and others' mental states. They typically expressed a desire for more intimacy whilst remaining fearful that they would be hurt or rejected as a result. It was hypothesised that negative internal working models of caring relationships, formed from early experiences in their family, had resulted in a deep

suspicion of close relationships and a continued anticipation of betrayal and rejection. Such a hypothesis has clear support from other studies. Blatt and Zuroff (1992) review a range of studies which suggest that a lack of consistent care, nurturance and support from parents and parental exercise of excessive authority, control and criticism, are associated with depression in later adult life. A number of other studies reviewed in the introduction have also consistently demonstrated the relationship between insecure attachment in infancy and difficulties in interpersonal relationships and styles of relating in adult life (e.g. Horowitz and Vitkus, 1986).

#### **4.4 Evaluating the Study's Findings**

The five criteria for evaluating the reliability and validity of these research findings are discussed below.

##### **Auditability**

For research to be auditable it must actively expose the processes and interpretations made so that these can be scrutinised by others. By opening the research in the ways described below the reader can develop their own interpretations and explanations of the data.

The analytic process was detailed in the method and results section. Whilst the first stage of analysis remained close to the actual data, later stages, particularly the development of an emerging theoretical account, relied more heavily on the author's interpretations of the central issues. It was therefore important to detail the personal reactions, assumptions and interpretations made by the author so that the reader can judge the researcher's influence in the shaping of the emerging account (Bannister et al., 1994). This was done in two ways. First, the introduction outlined the author's preliminary ideas and hypotheses and the research on which these were based. Second, the author used a research diary (appendix 9) to provide a reflexive account of the research process.

### **Respondent Validity**

The author attempted to validate the study by feeding back the hand-written notes to each participant after each interview and by feeding back the emerging analysis to two participants in each group (appendix 13). In each case they were asked whether the account reflected their own experiences. As can be seen in appendix 14, both groups of participants agreed with most of the codes and categories generated in the research. Their comments served to enrich the themes and theory developed rather than suggest a need for major modifications or changes. Yet these results must be treated with caution. Some authors have questioned whether this is a suitable method for assessing validity given that participants may not challenge the researcher if the researcher is perceived to be an 'expert' in the field (Henwood and Pigeon, 1995).

### **Inter-rater Reliability**

An independent rater judged the accuracy with which the author had categorised segments of text (appendix 12). Inter-rater reliability was good throughout although higher for code than category assignment. This might have been expected considering basic codes represent the level of analysis most 'close to the ground'. Of course the inter-rater reliability study only evaluated the codes and categories generated for participants' responses to two research questions. No inter-rater reliability data was obtained for the other questions; to do so would have placed unreasonable demands on the independent rater.

### **Generativity**

Generativity refers to the extent to which the research facilitates further issues and questions for investigation. The research has a number of important clinical implications and points to several useful and potentially fruitful areas for further investigation (explored in following sections).

### **Rhetorical Power**

The final way of evaluating the study concerns the rhetorical power of the presented findings. Do the ideas presented in the thematic and theoretical analysis provide a

convincing account of the issues explored? Ultimately, this is for the reader to decide, although the analysis has been reviewed by the supervisor and other researchers in this field.

#### **4.5 Methodological and Conceptual Issues**

##### ***a) The generalisability of the research findings***

Qualitative methods do not set out to recruit large numbers because the aim is depth of understanding (Silverman, 1993). Yet the limited sample raises several questions about the generalisability or 'transferability' (Henwood and Pidgeon, 1992) of the results and theory developed. First, the sample only contained participants who volunteered to participate. Was there something about the interview or the nature of the study that was particularly frightening for those unwilling to take part? Were different social issues relevant to this group? Second, potential participants who the recruiting clinicians thought might become overly distressed by the nature of the questions asked, were not approached. Why was the interview likely to be distressing for these people? Do they represent a group who find social relationships particularly threatening? Third, the research artificially selected people who had either schizophrenia or depression. Yet a large percentage of people suffering from schizophrenia are also moderately depressed. What social issues are pertinent for this group? Would people in this group have difficulties in 'reflective-functioning'? Fourth, almost all the participants in this study were fairly reliant on mental health services (particularly day care support). Would the results apply to people coping more adequately in the community?

A final sampling issue relates to the selection of people diagnosed with schizophrenia. A number of authors are now questioning the validity of the term 'schizophrenia' as a unitary construct (e.g. Boyle, 1990). Bentall (1993) argues that there is no convincing evidence of a schizophrenic syndrome. He argues that because the reliability and validity of the diagnosis is poor (Bentall, Jackson and Pilgrim, 1988) and the diagnosis fails to predict course, outcome or response to treatment (Kendell, 1989; both cited in Bentall, 1993), it is better to refer to specific symptoms or to the 'schizophrenias'. In

this research the different symptoms were grouped together although, in reality, all the S group participants suffered from either paranoid delusions or hallucinations. Perhaps different types of 'schizophrenic' symptoms impact on social relationships and social functioning in different ways. What are the social issues for people suffering from disorganised speech, grossly disorganised behaviour or the 'negative' symptoms that characterise the 'schizophrenic' syndrome?

***b) The inability to reflect on mental states: A developmental sequence or the effect of an 'illness'?***

A developmental framework has been proposed to provide a tentative account for the responses given by each group of participants to the research questions. Whilst the theory attempts to explain the data generated in the research it is also important to speculate briefly about other alternative explanations. Perhaps the interpersonal and social difficulties reported by participants occur purely as a result of their 'illness'. For example, maybe the difficulties experienced by the S group in reflecting on their own or others' mental states is a by product of the cognitive disorganisation and neuropsychological deficits that appear to accompany schizophrenia (Mueser, Bellack, Douglas and Wade, 1991). Rather than reflecting a disability that developed early in life, this disability may only be a temporary effect of an illness and one that might improve during recovery. Clearly this is a hypothesis that can be tested using either a quantitative or qualitative methodology. The difficulty with such an explanation is that it does not account for the lonely and isolated life many of the participants reported before the impact of symptoms.

**4.6 Implications for Clinical Practice and Service Delivery**

The research has a number of important implications for both increasing these groups' abilities to form relationships with others and to increase the amount (and desired type) of social support available to them. These are reviewed below.

#### ***a) Community based and 'macrosocial' interventions***

Both groups reported feeling lonely and isolated. This emphasises the need for structured interventions aimed at network building (Parry, 1988). Clubs, societies or self help groups could be formed to bring together people previously isolated in the community (Brugha, 1995). These may foster mutual support and reduce isolation. A number of descriptions and evaluations of such interventions have been documented in the literature (reviewed in Brugha, 1995).

The results of this research have several possible implications for such network enhancing strategies. It suggests that people with schizophrenia may benefit more from interventions which aim to increase their contact with people suffering from similar difficulties. Certainly S group participants appeared to make social comparisons with people similar to themselves and many valued the increased social contact experienced through mental health services. The research also suggests that too much social contact, or contact with people expressing too much emotion, is likely to be aversive for them. It is hypothesised that each of these factors occur because this group have difficulties in reflecting on their own and others' mental states. Situations requiring this ability may be aversive for this group and will therefore be avoided.

For people suffering from depression it would appear to be more appropriate to attempt interventions which provide them with more contact with people leading 'normal' lives. D group participants tended to make social comparisons with people in the general community although many reported lowered self esteem as a result. Some thought that a valued role (or job) would increase their self esteem. A valued role and increased self esteem may well assist them in their attempts to integrate themselves into the community.

Both groups of participants also reported interpersonal difficulties that arose from the stigma they received from the general population. This also stresses the importance of the work being conducted by organisations like MIND which attempt to educate the general public about the effects of mental illness and reduce the stigma that arises from prejudice and mis-information. Interventions aimed at enhancing individual skills and



competencies (see below) may not be of value if strong adverse cultural norms serve to maintain undesirable behaviour.

### ***b) Case management***

Many D group participants expressed a clear desire for services to be better organised so that a more constructive, planned approach could be taken with patients. Some felt they were not given enough consistent support in their attempts to re-integrate into the community. Others thought they were just left to drift along in services (“we are basically herded like cattle”) and that no one took an interest in them unless they had an acute crisis. Such comments suggest a need for more efficient strategies for planning and co-ordinating services on behalf of patients (certainly in the services from which these participants were sought). Individual case management (Thornicroft, Breakey and Primm, 1995) would encourage individualised and focused treatment approaches. Leaving people ‘safe’ but ‘trapped’ in services seems an awful waste of the limited resources that are available.

### ***c) Social skills training***

The research also has potentially important implications for social skills training, particularly for people with schizophrenia. Several authors are now emphasising that social skill is a ‘construct’ consisting of many variables often fairly loosely related to each other (Sheppard, 1987). Smith, Bellack and Liberman (1996) suggest that social skills are made up of ‘molecular skills’ (e.g. eye contact and verbal fluency), ‘molar’ skills (e.g. initiating conversation), social perception (e.g. self awareness, affect and social cue recognition) and cognitive problem solving abilities (e.g. appraising a social situation and planning suitable responses). Given the complexity of the processes involved in being ‘socially skilled’ it is perhaps unsurprising that the effects of social skills training often fail to generalise across situations and response systems.

This research suggests that for people with schizophrenia, the inability to reflect on their own or others’ mental states (i.e. their social perception) may lie at the root of their social skill deficits. It is interesting that researchers have failed to identify any clear differences between matched schizophrenic patients and non-patient pairs in their

'molecular' or 'molar' abilities (Lindsay, 1984; Sheppard, 1987). It may be an inability to apply these skills appropriately in response to others that is particularly difficult for people with schizophrenia.

The research suggests an important role for therapeutic or educational techniques that might help this group to reflect on mental states. Through gaining an increased understanding of the desires and emotions of others this group may be helped to use their social skills more appropriately. Role plays should concentrate on helping this group to 'mesh' specific 'molecular' and 'molar' social skills with the beliefs, emotions and desires of others in a flexible and sensitive way. The more such approaches succeed in this task, the more generalisation there is likely to be beyond the treatment setting.

#### ***d) Therapeutic work***

The research also points to important therapeutic work that could be conducted either individually or in group settings. Therapeutic techniques which aim to increase a person's ability to reflect on their own or others' mental states are likely to be important for people with schizophrenia. For people with depression, therapeutic work clearly needs to challenge the negative internal models formed about relationships. A number of cognitive and psychotherapeutic approaches have this as a core aim (Brugha, 1995).

#### ***f) Preventative work***

One of the speculations made in this research was that early interaction with peers may be a crucial time in which a person learns the rules and conventions that govern social relationships and peer functioning. S group participants appeared to have particular difficulties relating to peers at school. One hypothesis generated suggested that this was a result of the difficulties they experienced in reflecting on mental states; difficulties which in turn hampered their ability to learn the social rules and conventions required for peer functioning. It suggests that this period of life may be a crucial time in which to apply early intervention and prevention strategies. If this group could be helped at an early stage (by identifying those who have these particular difficulties at

school), then we might prevent the loneliness and lack of social support experienced later in life.

#### **4.7 Recommendations for Future Research**

##### ***a) Testing-out the emerging theoretical framework***

Due to limited resources, this research did not test out the emerging theoretical framework through new theoretically driven sampling or through the search for 'negative' cases which might not fit the framework (although some attempts to validate the theory were made in the respondent validity study). Clearly this might help to confirm, or extend, the theory developed. For example, in testing the theory that S group participants suffered from difficulties in 'reflective-functioning' it might be useful to ask further participants the following questions: Do you sometimes find it difficult to work out what is going on in your mind? Can it be difficult to work out what people are thinking and feeling? What do other people think of you? Why do people react to you in this way?

##### ***b) Further evaluation of the study's findings***

The rhetorical power of the study will be further examined by feeding back the results of the study to many of the professionals (in two organised meetings) who helped to recruit participants. Respondent validity will be further evaluated by sending a summary report of the emerging themes and theoretical framework to each of the participants. Both groups will be asked to comment and provide feedback.

##### ***c) Further research in the field***

A number of suggestions have been made regarding how to test out the emerging theoretical framework. Yet numerous other research questions arise from this research and from the hypotheses generated within it. For example, what explanations do people with schizophrenia give for the actions, desires and beliefs of others? Do 'reflective-functioning' difficulties exist before the development of schizophrenic symptoms? How do the different symptoms of schizophrenia impact on a person's ability to relate to others? Why did participants in the D group compare themselves to

people in the general community when social comparison theory might predict otherwise? This research raised more questions than answers. But they are vital questions if we are to better meet the social needs of people with long-term mental health problems.

## **5. CONCLUSION**

Research aimed at understanding the huge range and complexity of factors that impinge on these groups' abilities to form relationships with others, and to utilise the social support potentially available to them, is at a very early stage of development. This research provides a first step in unravelling some of this complexity. A theoretical framework has been developed from participants' responses to the research questions. Yet this must be treated tentatively. It provides a set of hypotheses. Further research must confirm and expand the theory developed. It must also determine whether the theory can be generalised beyond the specific sample of participants selected for this research. Yet the theory has several implications for clinical practice and service delivery; implications which may prove to have an important impact on the well-being of people with long-term mental health needs.

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## **APPENDIX 1**

### **The Manchester Scale**

# The Manchester Scale

## Ratings

All ratings are on a 5-point scale:

- 0. Absent
- 1. Mild
- 2. Moderate
- 3. Marked
- 4. Severe

### Ratings made by replies to questions

- Depressed ☐
- Anxious ☐
- Coherently expressed delusions ☐
- Hallucinations ☐

### Ratings made by observation

- Incoherence and irrelevance of speech ☐
- Poverty of speech, mute ☐
- Flattened affect ☐
- Incongruous affect ☐
- Psychomotor retardation ☐

### Side-effects

(Rate as: 0. Absent; 1. Mild; 2. Marked)

- Tremor ☐
- Rigidity ☐
- Dystonic reactions ☐
- Akathisia ☐
- Difficulties with vision ☐
- Other (specify) ☐

### Guide lines for the use of the five-point scales

In making these ratings the psychiatrist is expected to use his clinical judgement to make overall assessments about the patients in each particular area. For example, in making the rating for depression the rater should be expressing his own clinical assessment of the severity of depression, based on both the patient's demeanour and behaviour during the interview, and the history that the patient has given concerning depression. It should be emphasised that a morbid rating (2, 3, or 4) for depression does not imply that the principal diagnosis made will necessarily be an affective illness.

### General rules for the five-point scale

- 0. Mild. The item is for all practical purposes absent.

- 1. Mild. Although there is some evidence for the item in question, it is not considered pathological.
- 2. Moderate. The item is present in a degree just sufficient to be regarded as pathological.
- 3. Marked. See individual definitions.
- 4. Severe. See individual definitions.

## Depression

This does not only include the actual behaviour observed at interview — dejected pose, sad appearance, despondent manner — but should be a clinical rating which expresses the overall assessment of depression, and the contribution that this abnormality of affect is making to the abnormal mental state being rated. Whether there is a discrepancy between depression observed at interview and depressed mood reported as having been experienced in the past week, the rating made should be the greater of the two ratings.

- 0. Absent. Normal manner and behaviour at interview. No depressive phenomena elicited.
- 1. Mild. Although there may be some evidence of depression — occasional gloominess, lack of verve, etc. — the rater does not consider that it is pathological, or takes it to be an habitual trait not amounting to clinically significant depression.
- 2. Moderate. The patient is thought to be clinically depressed, but to a mild degree; or occasional depressed feelings which either cause significant distress or are looked upon by the patient as a significant departure from his usual self, in the past week.
- 3. Marked. The patient is thought to be clinically depressed, in marked degree; or frequent depressed feelings as described in No. 2 in the past week, or occasional extreme distress caused by depression.
- 4. Severe. The patient is thought to be clinically depressed in extreme degree. Major depressive phenomena should be present; strongly held suicidal ideas, uncontrollable weeping, etc; or depression has caused extreme distress frequently in the past week.

## Anxious

In addition to direct evidence of anxiety observed by the rater at interview, this rating should express the rater's view of the contribution which morbid anxiety is making to the mental state under consideration. (There may be some physiological signs of sympathetic over-activity, moist palms, mild tremor, blotchy patches in skin, etc.). Where anxiety is of such a degree that there is associated motor agitation, this will be rated on this key as not less than No. 3. Where there is a discrepancy between anxiety as observed at interview and anxiety expressed in the previous week the rating made should be the greater of the two ratings.

## THE MANCHESTER SCALE

0. Absent. Normal mood at interview.
1. Mild. Such tenseness as the patient displays is thought either to be an habitual trait not amounting to pathological proportions or is thought to be a reasonable response to the interview situation.
2. Moderate. The patient is thought to display a mild degree of clinically significant anxiety or tension; *or* anxiety sufficient to cause significant distress has occurred occasionally in the past week.
3. Marked. The patient is thought to display a marked degree of clinically significant anxiety or tension. He may be apprehensive about the interview and need reassurance, but there are only minor disruptions of the interview due to anxiety. There may be associated motor agitation of mild degree; *or* anxiety sufficient to cause significant distress has occurred frequently in the past week, *or* anxiety has caused extreme distress for the individual concerned occasionally in the past week.
4. Severe. The patient is thought to display an extreme degree of clinically significant anxiety or tension. He may be unable to relax, or there may be major disruptions of the interview due to anxiety. There may be associated motor agitation of marked degree, *or* a fearful pre-occupation with impending events; *or* anxiety has caused extreme distress for the individual concerned frequently in the past week.

### Flattened, incongruous affect

Flatness refers to an impairment in the range of available emotional responses; the patient is unable to convey the impact of events while relating his history, and cannot convey warmth or affection while speaking about those near to him.

0. Absent. Normal affect at interview.
1. Mild. The patient may be laconic, taciturn or unresponsive in discussing emotionally charged topics, but the rater considers that this is an habitual trait rather than a sign of illness.
2. Moderate. Clinically significant impairment of emotional response of mild degree. Definite lack of emotional tone discussing important topics; *or* occasional but undoubted incongruous emotional responses during the interview.
3. Marked. Clinically significant impairment of emotional response of marked degree. No warmth or affection shown. Cannot convey impact of events when giving history, no concern expressed about future; *or* frequent incongruous responses of mild degree or occasional gross incongruity.
4. Severe. Clinically significant impairment of emotional response of extreme degree: no emotional response whatever elicited; *or* gross frequent incongruity; fatuous, supercilious, giggling, etc., in such a way as to disturb interview.

### Psychomotor retardation

0. Absent. Normal manner and speech during interview. Questions answered fairly promptly; air of spontaneity and changes of expression.

1. Mild. Although there may be evidence of slowness or poor spontaneity the rater considers that this is either an habitual trait or that it does not amount to clearly pathological proportions.
2. Moderate. The rater detects slowness, or lack of spontaneity at interview and attributes this to psychiatric illness: it is just clinically detectable. Delays in answering questions would merit this rating providing that the rater considers that it is part of a morbid mental state rather than an habitual trait of the patient.
3. Marked. Psychomotor retardation attributable to psychiatric illness is easily detectable at interview and is thought to make a material contribution to the abnormalities of the patient's present mental state.
4. Severe. Psychomotor retardation is present in extreme degree for the individual concerned.

### Coherently expressed delusions

0. Absent. No abnormality detected at interview.
1. Mild. Eccentric beliefs and trivial misinterpretations: that bad weather is caused by nuclear tests; superstitions, religious sects, etc.
2. Moderate. Over valued ideas and ideas of reference, or undoubted misinterpretations. Special meanings.
3. Marked. Undoubted delusions or delusional perception are described as having occurred in the past month but the patient denies that he still holds the beliefs at present; *or* delusional ideas are expressed but they are not strongly held or incorrigible.
4. Severe. Undoubted delusions are present and are still held by the patient.

### Hallucinations

The rater must therefore decide whether hallucinations have occurred in the *past week*; if so, whether they are true — or pseudo-hallucinations, and how frequently they have occurred.

0. Absent. No evidence of hallucinations.
1. Mild. The hallucinatory experiences reported to the rater are not definitely morbid, hypnagogic hallucinations, eidetic images and illusions.
2. Moderate. Pseudo-hallucinations of hearing and vision; hallucinations associated with insight — e.g. those following bereavement.
3. Marked. True hallucinations have been present in the past week but have occurred infrequently.
4. Severe. True hallucinations have occurred frequently in the past week.

### Incoherence and irrelevance of speech

0. Absent. No evidence of thought disorder.
1. Mild. Although replies are sometimes odd the abnormalities fall short of those required for thought disorder: it is always possible to understand the connection between ideas.
2. Moderate. Occasional evidence of thought disorder elicited, but patient is otherwise coherent.
3. Marked. Frequent evidence of thought disorder but meaningful communication is possible with the



## THE MANCHESTER SCALE

patient; *or* several episodes of incoherent speech occur.

4. Severe. Replies difficult to follow owing to lack of directing associations. Speech frequently incoherent, without a discernible thread of meaning.

### Poverty of speech, mute

0. Absent. Speech normal in quantity and form.
1. Mild. Patient only speaks when spoken to; tends to give brief replies.

2. Moderate. Occasional difficulties or silences but most of interview proceeds smoothly; *or* conversation impeded by vagueness, hesitancy or brevity of replies.
3. Marked. Monosyllabic replies; often long pauses or failure to answer at all; *or* reasonable amount of speech, but answers slow and hesitant, lacking in content, or repetitions and wandering, that meaningful conversation was almost impossible.
4. Severe. Mute throughout interview, or speaks only two or three words; *or* constantly murmuring under breath.

## **APPENDIX 2**

### **Participant Details**

## **OUTLINE INFORMATION**

### **THE D GROUP**

#### **1. Support received**

In hospital 1  
Living in the community with regular day care support 6  
Living in the community with once a week therapy 1

#### **2. Domestic Circumstances**

Bed and breakfast accommodation 1  
Alone in a one bedroom flat 4  
Alone in a three bedroom house 1  
Residential accommodation 1  
In the family home 1

#### **3. Employment**

##### ***a) Present***

Unemployed 7  
Unemployed with voluntary work 1

##### ***b) Length of unemployment***

1-2 years 1  
3-5 years 1  
6-8 years 2  
8-10 years 2  
15+ years 2

##### ***c) Type of past employment***

Medical physics technician 1  
Nursing 1  
Civil service 1  
Bus driver 1  
Restorer of oil paintings 1  
Unskilled labouring 1  
Self employed financial advisor 1  
Teaching English as a foreign language 1

#### **4. Educational achievement**

No formal exams 3  
CSE's 1  
No qualifications at school but passed a civil service exam 1  
O-Levels and professional qualification (nursing or medical physics technician) 2  
College degree 1

## **THE S GROUP**

### **1. Support received**

In hospital 1  
Living in the community with regular day care support 6  
Living in the community with occasional visits from a CPN and once a week therapy 1

### **2. Domestic Circumstances**

Alone in a bed sit 1  
In a residential home 2  
Alone in a one bedroom flat 3  
With partner in a one bedroom flat 1  
In the family home 1

### **3. Employment**

#### ***a) Present***

Unemployed 6  
Unemployed with voluntary work (organised through mental health services) 2

#### ***b) Length of unemployment***

3 - 5 years 1  
6 - 8 years 3  
8-10 years 1  
10-15 years 1  
15+ years 2

#### ***c) Type of past employment***

Secretarial 1  
Unskilled manual 4  
Skilled manual 3  
(Unlikely jobs e.g. private detective 2)

### **4. Educational achievement**

No formal exams 4  
O-Levels 2  
O-Levels and further technical qualifications 2

### **APPENDIX 3**

#### **The Emotional Difficulties or Symptoms Reported by the Participants**

## **ADDITIONAL INFORMATION ABOUT THE EMOTIONAL DIFFICULTIES OR SYMPTOMS EXPERIENCED BY THE PARTICIPANTS**

The categories and codes generated from participants' descriptions of their emotional difficulties or symptoms are presented below. The number presented after each code or category refers to the number of participants who gave a response which could be included in it. Exemplary quotations are used to illustrate certain categories.

### **THE D GROUP**

#### **1. The Beginning of the Emotional Difficulties**

##### ***a) Length of time***

1-2 years ago 1  
3-4 years ago 1  
6-8 years ago 2  
10-15 years ago 1  
15-20 years ago 1  
Since a child 2

##### ***b) Emotional and practical difficulties experienced***

###### **Depression** 8

Really low/depression 7  
Very low (anger expressed) 2  
A malaise 1

###### **No hope for future** 3

Feel no future 1

*"I suppose I keep going just by living day to day".*

Sense of pointlessness 1

Feeling that everything goes wrong for the participant 1

*"Have you seen the film 'Last Chance' with Clint Eastwood in it? I watch it every now and again. Eastwood says in it at one point that 'some people are born with the finger pointed at you'. That's my life. Trouble always finds me. Everything every day. Always it finds me. I suppose I was born with the finger on me. Its a cunt isn't it".*

###### **Feelings of anxiety** 2

Agoraphobia 1  
Bulimia 1

###### **Biological illness** 1

*"I got the illness, something biological - a disease of the nervous system".*

###### **Other**

Low self esteem 1

*"It's as if I'm fragile and low underneath".*

Psychotic periods earlier in life 1  
*"I've worked all my life but for what".*  
Fighting my father in my sleep 1  
Alcoholism 2

## **2. Emotional Difficulties Currently Experienced**

Depression 8  
Depression, worse when exacerbated by interpersonal problems 2  
Deep depression 5  
Get so low that I get periods of confusion 1

A mental illness 1  
A nervous disease 1

Loneliness/emotional isolation 6  
Loneliness 4  
Crave for affection 1  
*"I crave for affection. But perhaps I crave too much - people cannot really give it can they. Maybe they get put off".*  
Deep loneliness expressed as a physical pain 1

Anger at others 2  
Can make me angry 2

## **3. The Course of the Emotional Difficulties over Time**

Varying course of depression 5  
Depression goes up and down 4  
*"I feel I go up and down like a roller coaster, although generally I just feel low and very depressed. There seems to be no future you see. Some days though I feel a bit better although I sometimes go over the top - I can't seem to find a middle ground. It's like being in a big tube, all greased in the inside. The more I try to climb up it the more I seem to slip back down- and when I slip I just seem to keep going. At the moment I'm fighting hard just to keep my head up - god even my bulimia seems to be coming back again. Its a continuous battle - sometimes I just feel like giving up".*  
*"Some things do make it worse I suppose. If say a friend says they will ring but they don't, particularly if its someone I'm fond of".*

Depression worsened 2  
Gradually got worse 2  
*"Its just built up bloody disease".*

Depression become less severe 1  
Got more mellow over time 1

Wasted my life 3  
*"All my years have been wasted ones. Nothings been got of them". "It feels that everything I've done has been pointless".*

### Lack of rewarding activities 3

*"Well I don't really do anything - I do go to the library sometimes".*

### Loneliness/isolation 4

More alone than I ever was/extreme loneliness 3

*"But now I've lost everything. I could lie in bed for six months and no-one would know I've gone. That's right, bloody well no-one. I've got a telephone but it never gets used. It would be really nice even to get a card from someone. Even my sons - I've no idea how their life is now. I have no contact. Absolutely no contact. Yes, it does hurt at times. I've spoken to the Samaritans. They said everything would be different after a while. Different! Bloody well isn't it. Is it!"*

## **THE S GROUP**

### **1. The Beginning of the Emotional Difficulties**

#### ***a) Length of time***

6-8 years ago 2

9-10 years ago 1

10-15 years ago 1

15-20 years ago 2

30+ years ago (since 17) 1

Since a young child 1

#### ***b) Emotional and practical difficulties experienced***

### **Voices 7**

Several voices 7

*"it was like all these voices were just screaming in my ear". "The voices would tell me the nasty things that people were saying about me. That I was lazy, an imbecile, that I was rotten and things like that".*

### **Paranoid thoughts 7**

Paranoid thoughts 7

*"I thought someone had bugged the flat. They were listening to my thoughts and planting these voices in my head". "I thought the devil was after me". "I thought people wanted to murder me". "I thought I must be an alien and that people wanted to get me". "I suppose I thought my parents would murder me". "It was like clocks and aeroplanes would say nasty things to me".*

### **Feelings of anxiety 4**

Got very anxious because of what was happening to me 2

Didn't want to go out/Agoraphobia 2

Thought I was going to die 1

*"they said the murder was my fault".*

### **Delusions 4**

*"it was funny but I really thought I was Leonardo De Vinci".*

*"My girlfriend could tell what I was thinking you see, the thoughts just came out of my ears".*



### Behavioural disturbance 2

Acting strangely 2

*"it was like my behaviour just became weird". "I would run about and shout at the trees".*

### Thought disturbance 3

I broke down, just flipped 2

I was only half there and didn't realise what was happening, things were not real 1

*"it was a nightmare, like going through chaos, sinking through railway lines, like going through the middle of the world".*

Thoughts became overwhelming 1

*"my mind was so full of problems I began to exhaust my mind".*

I got weird thoughts 1

### Other

A spiritual experience 2

*"I think I must have been having a spiritual experience with God".*

## 2. Emotional Difficulties Currently Experienced

### Cognitive disruption 4

Strange thoughts and ideas 3

Things get fragmented 3

*"it sometimes feels like bits of my mind are carried off by other bits and destroyed".*

### Paranoid thoughts 5

### Voices 5

*"they are really nasty. They call me a slag, a slut, cheap and things like that". "They call me lazy, rotten and things".*

### Visions - 3

*"its like different faces suddenly appear out of others, and they pull really nasty faces". "Like two years ago I was feeling really guilty and I saw Jesus Christ coming out of the sky on a white horse".*

### No problems now 1

*"I'm going to be a private detective you see".*

## 3. The Course of the Emotional Difficulties over Time

### a) Type

Voices 5

Having to move 1

A series of psychotic episodes 6

Several moves into psychiatric hospital 6

Exhaustion of the mind 1

## ***b) Comments***

### Wasted life 1

My life has been a waste of time 1

*"immediately I get myself sorted I end up back in hospital, right back where I started".*

### Practical abilities disrupted 3

Its left me with no abilities to do anything 3

### Emotional difficulties have become less severe 4

Suffered less over time 4

### Others

Hospitals should be for patients not criminals 1

Doctors keep me alive 1

I've lost contact with friends 1

## **APPENDIX 4**

### **The Interview Schedule**

## **THE INTERVIEW**

### **A. GENERAL INFORMATION**

*Q:- I'd like to start the interview by asking some general background information. Could you begin by telling me a little about your current circumstances?*

***Areas to cover***

Age  
Domestic circumstances  
Employment past and present  
Educational history

### **B. PAST AND CURRENT EMOTIONAL DIFFICULTIES**

*Q:- Can you tell me when your emotional problems started?*

***Areas to cover***

Emotional (psychiatric) difficulties experienced  
Practical difficulties experienced  
Relationship and interpersonal problems experienced  
Explanation for the development of the emotional difficulties  
Significant others' views on the cause of the emotional difficulties

*Q:- Can you tell me what sort of emotional problems you are experiencing at present?*

***Areas to cover***

As above  
Current life stresses

*Q:- Can you tell me how your emotional difficulties have changed over time?*

***Areas to cover***

As above

### **C. CURRENT RELATIONSHIPS**

*Q:- Could you tell me a little about your current relationships?*

***Areas to cover***

Participants thoughts about:-

- 1) Family
- 2) Friends
- 3) Professionals

For the most important person in each category:-

Thoughts and feelings expressed about the level of contact with this person

What sort of things they do with this person

How it feels to be with this person

What they think they gain from the relationship (e.g. self esteem, companionship, informational support, practical support etc.)

Negative aspects of the relationship

Type of support the person wants from the relationship and the circumstances in which they try to access this support

Whether their ideal levels of support from this person match their perceived levels of support

#### **D. INTERPERSONAL PROBLEMS**

*Q:- Can you tell me a little about what you feel friends are for?*

*Q:- In what sorts of ways do you go about making friends?*

*Q:- I wonder if you could tell me about some of the difficulties you have in relating to other people?*

*Q:- Do you have any views about why these things are difficult?*

#### **E. PAST RELATIONSHIPS**

*Q:- Can you tell me about your memories of your early relationships with family and friends?*

##### ***Areas to cover***

First memories as a child of the participant's relationship with parents

Memories of relationships with parents and peers while in

1) Primary school

2) Secondary school

What were the positive and negative aspects of these relationships?

Did the participant's early experiences of relationships have an impact on his/her feelings about present relationships and the types of interpersonal problems experienced?

#### **F. THE RELATIONSHIP BETWEEN MENTAL ILLNESS AND RELATIONSHIP DIFFICULTIES**

*Q:- Do you think that relationship difficulties contributed to your emotional problems in any way? Did relationships help you in any way?*

*Q:- Have your emotional problems changed the sort of relationships you have with other people, either in a positive or negative way?*

##### ***Areas to cover***

Impact of symptoms

Impact of hospitalisation

Impact of stigma

## **G. ROLES OF SERVICES**

*Q:- You have talked about some of the positive and negative experiences you have in relating to other people. Would you like things to be different? If so, how would they be different?*

*Q:- Do you have any views about the sorts of things that could be done to make these things less difficult? Are you receiving any help at present?*

### **Areas to cover**

Possible role of family, residential services, day support and oblique facilities (employment and other structured activities), evening services/facilities and different therapeutic models.

## **H. DEBRIEFING**

*Q:- Could you tell me how you feel having completed the interview?*

*Q:- What was it like talking to me about these issues?*

*Q:- Has taking part raised any particular difficulties for you?*

*Q:- Finally, I would like to ask you whether there is anything that was not covered during the interview that you would like to talk about now?*

### **To be read out after each interview:-**

*Thank you for taking part in this interview. It will help me to come to some sort of understanding about the sort of relationship difficulties people feel they have and what sort of things they feel could be done to help. I will be looking for common themes between the views of people who are suffering from similar types of emotional difficulties.*

*I would like to read to you the comments that you made and that I have recorded during the interview. If I have got something wrong then please tell me.*

*Q:- Do you think I have managed to make an accurate recording of what you have told me? Would you like me to change anything or leave anything out when I write up my research?*

*If any issues arise out of the research, or if you have any questions that you were unable to ask today, then please contact me on \_\_\_\_\_ (work telephone number). If I am not available then please leave a message and I will return your call as soon as possible.*

*I would like to send you a summary of the emerging analysis. If you would like to receive this please tell me now: \_\_\_\_\_. I would be grateful if you would be willing to write back to give me your comments on what I have written.*

*I will be providing a summary of the study's findings which will be available after November 1997. If you would like a copy then please tell me now:- \_\_\_\_\_.*

*Thank you for your time and for being willing to take part.  
Time interview ends:-*

**L RESEARCHER'S IMPRESSIONS (To be recorded after the interview)**

*Q:- What was the researcher's impression of the meeting?*

*Q:- What feelings were aroused by the participant?*

*Q:- How easy was it to establish a working relationship during the meeting?*

## **APPENDIX 5**

### **Letters Confirming Ethical Approval**



10 February 1997

Mr Nicholas Lake  
Clinical Psychologist Trainee  
Salomons Centre  
David Salomons Estate  
Broomhill Road  
Southborough  
Tunbridge Wells TN3 0TG

Dear Mr Lake

**(Please quote this reference number in correspondence about this study)**

The Current Relationships, Perceived Social Support and Interpersonal Problems of People Suffering from the Symptoms of Schizophrenia: A Qualitative Study Comparing the Personal Accounts of People Diagnosed with Schizophrenia and Depression

This study, a simplified version of the study originally submitted to the Local Research Ethics Committee at their November meeting, was reviewed by the Committee again at their meeting on 5 February. The study's title had been changed slightly to reflect the new simplified design.

Members felt that the amended study was better thought out and more practicable and they approved it in principle. However, they noted that the *Consent Form* did not have the study title on it. If, as is usually the case, the *Information for Potential Participants Form* is to be given to the research subject and the *Consent Form* kept by the researcher, then the *Consent Form* should have the study's full title on it.

If you could either send me a new version of the *Consent Form* with the study's title on it (or confirm that it will remain attached to the *Information for Potential Participants Form*, then I will be authorised to confirm approval by Chairman's Action for the study to proceed.

I look forward to hearing from you.

Yours sincerely

Ethics Committee Administrator

Mr Nicholas Lake  
Top Flat  
85 Sackville Road  
Hove BN3 3WE

Dear Mr Lake

**(Please quote this reference number in correspondence about this study)**

The Current Relationships, Perceived Social Support and Interpersonal Problems of People Suffering from the Symptoms of Schizophrenia: A Qualitative Study Comparing the Personal Accounts of People Diagnosed with Schizophrenia and Depression

Thank you for telephoning me this afternoon to clarify the matter of confidentiality, about which the Local Research Ethics Committee had expressed some concerns.

I now understand that none of the interviews will in fact be taped. The recording of interviews will be done by you, using handwritten notes only. These notes will be read back to the interviewees, for them to confirm that they are happy with them. The data from the notes will then be entered into your computer but in an anonymised form and the original, handwritten, notes will be destroyed.

The Committee can now be assured regarding the safeguarding of the confidentiality of this vulnerable group of people. This being so, I am authorised by the Chairman of the Committee to confirm approval of the study, by Chairman's Action, as was agreed at the meeting at which it was reviewed a second time.

Yours sincerely

Ethics Committee Administrator

## **APPENDIX 6**

### **The Participant Information Sheet**

## **RESEARCH PROPOSAL**

***Researcher :- Nick Lake***

### **INFORMATION FOR POTENTIAL PARTICIPANTS**

Dear Sir/Madam

I am currently undertaking a piece of research investigating how different people view the support they receive from family, friends and professional staff and how important they feel this support is. I also want to ask people about the positive aspects and types of difficulties they feel they have in their relationships with other people.

This project arises out of other research which suggests that people who are suffering from different types of emotional distress may have different ideas about their relationships. This study aims to come to some sort of understanding about why this is so. The project therefore also aims to ask people how they feel about themselves, what difficulties they feel they are currently having, and what they feel about their early life and their family.

The research has several important implications. Some people report feeling very lonely and isolated and some report that they find it very difficult to form relationships with other people. It is hoped that the research will give us an increased understanding of how these people may be helped and supported in overcoming these difficulties so that they can become less isolated and alone in the world. Other people report feeling that people are too intrusive or perhaps feel people should not really be trusted and then feel angry when people will not leave them alone. It is hoped that the research will increase our understanding of why people feel like this and what they would like people to do to decrease the anxiety and negative emotions this causes.

I would be very grateful if you feel you would be willing to meet with me to give me your views. *I am aware that this is very personal information and I would like to*

*stress that the information recorded during our meeting will remain strictly confidential. I will also ask you at the end of our meeting if there is anything you would like me to leave out. No information will be recorded during the meeting, or described in the write up of this research, that could possibly lead to your identification. During our meeting I will also ask you if you would like me to send you a summary of the completed project.*

*I expect our meeting will last for about an hour and a half. I want to stress that you can decide not to continue with the meeting at any stage and you do not have to give a reason for doing so. This will in no way affect the care you are currently receiving as a patient.*

If you do decide that you would be willing to participate would you please sign the consent form on the next page. This is to ensure that you have are willing to participate and that you have had an opportunity to ask any questions about the research that you might have. I will then try to contact you to arrange a first meeting, at a time that is suitable to you, so that I can explain things in a bit more detail. Thank you for spending the time to look over the proposal.

Yours sincerely

Nick Lake  
Researcher

## **APPENDIX 7**

### **The Pre-Interview Briefing Sheet**

## **THE INTERVIEW SCHEDULE**

### ***TO BE READ OUT TO EVERY PARTICIPANT BEFORE THE INTERVIEW BEGINS***

“Thank you for agreeing to take part in this research. As outlined in the research proposal I would like to get your views on the support you receive from family, friends and professional staff and how important you feel this support is. I would also like to ask you about the positive aspects and the types of difficulties you have in your relationships with other people, what you feel about yourself, what difficulties you are currently having, and what you feel about your early life and your family.

“I hope this research will give us an increased understanding of the difficulties people have with others and suggest ways in which people suffering from different types of emotional distress can be helped to overcome these difficulties. As I have already mentioned, I am carrying out this research during my final year of training in clinical psychology and will be writing up the findings for my dissertation project.”

“I would like you to read again the consent form that you were given before we met and for you to ask me any questions you have about this research. I will then ask you for your formal consent to begin our meeting”.

“I want to stress again that you can stop this meeting anytime you want. This will not affect the care you are currently receiving in any way”.

“I will not at any stage ask you to give me any details that could lead to your identification. Also, at the end of the interview, I will feed back what I have recorded during the interview and ask you to comment on it and ask if there is any information that you would like me to leave out. The results will be written up and I will send you a summary of the final report if you would like me to do so. I would be grateful for your comments on the report”.

### **[ALLOW TIME FOR PARTICIPANTS TO READ THE CONSENT FORM]**

“Do you have any questions?” (record)

*Interview date:-*

*Time interview began:-*

## **APPENDIX 8**

### **The Participant Consent Form**



## CONSENT FORM

Project Entitled:- The Current Relationships, Perceived Social Support and Interpersonal Problems of People Suffering from Schizophrenia or Depression: A Qualitative Study Comparing the Personal Accounts of People Diagnosed with Schizophrenia or Depression

Dear Sir/Madam

This form is to confirm that you would be willing to participate and to give your views in the proposed research. The nature and purpose of the study should have already have been explained to you by someone who works with you. You should also have had an opportunity to look at the proposal form and any questions you might have should have been answered. If you would be willing to participate then I will try to contact you fairly soon to arrange an initial meeting so that I can explain things in a bit more detail. I will then arrange a time for the main research meeting.

I do want to stress that any details I record during our meeting will remain strictly confidential and I will ask you at the end of our meeting if there is anything you would like me to leave out. No information will be recorded during the interview or described in the write up of this research that could possibly lead to your identification.

Thank you for being willing to participate and to give me your views.

Nick Lake (researcher)

-----  
*I (name):-*

*of (address):-*

*telephone number (for the purposes of arranging a meeting) :-*

*hereby consent to take part in the research, the nature and purpose of which have been fully explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw at any stage without necessarily giving a reason for doing so and that this will in no way affect the care I receive as a patient.*

*Signed (volunteer):-*

*Date:-*

*Signed (professional):-*

*Date:-*

## **APPENDIX 9**

### **The Research Diary**

## **RESEARCH DIARY**

### ***6th September 1996 - "Planning"***

Tony (my supervisor) has suggested that it might be useful to begin a research diary. Given the quantitative nature of the design I'm not sure whether I will use it in the research. However, I've decided it will be an extremely useful way of reflecting on my experiences. Maybe it will help inform what I do. I'm beginning to think that documenting my thoughts and personal opinions - my way of viewing life and the potential biases that I may have - is as important for quantitative research as qualitative research. After all, I am forming my own preconceived hypotheses and testing these according to my own view of reality. Is this the only way of viewing things?

So what has happened so far? The research week left me feeling anxious and confused. What did I really want to investigate? I suppose I wanted to choose something that would engage me at a personal level. To be able to really invest something of myself I suppose. I've thought about many of my own life questions. What am I here for? What is life really about? How can I integrate my psychological views with my views (which are very confused and ambivalent) about spirituality? The trouble was that these thoughts did not easily integrate themselves into a manageable research project. I'm not sure I can answer all my life questions in a year! How could I form these questions into clinically relevant questions that might help those suffering from severe emotional distress?

My decision was made after we had a day's teaching with Ron Coleman, a member of the 'hearing voices' network. It was inspiring! Perhaps there are ways that psychologists can really help people suffering from long term mental health problems. After my experiences working at MIND I had decided that it was an extremely frustrating area to work in. Treatment was dominated by drugs, there appeared little room for psychologists and I had left my work there feeling frustrated that I had not managed to form any 'real' contact with clients. It was as if they had no room for me. But how do social relationships operate for this group? Why was it so difficult for me to make 'real' contact? What affects do attachment models, social rules, early family experiences and so on, have on this group? Why has no real effort gone into investigating the social functioning of people with long term mental health needs? I now have my research questions and I'm excited and engaged. I also feel very excited that Tony is going to supervise me. I know I can learn a great deal from him and I'm excited at the prospect of getting to know him better. I suppose I admire the way he works. Maybe it will rub off on me!

### ***16th October 1996 - "Shaping"***

The research is coming together. I feel I have read almost too much and feel a bit overwhelmed by the amount of literature that is potentially relevant. But I now have my research questions and feel somewhat relieved that it has taken shape. Tony has played a vital role by helping me to tailor the research into manageable research questions. I think I wanted to answer every possible question all at the same time.

### ***21st October 1996 - "Specifying"***

I have somehow managed to complete my research proposal and have now submitted it for approval by the external examiner. I feel excited again although a little overwhelmed by the amount of work it will entail. Forty to sixty, two hour interviews feels a lot. I suppose I had better make sure I'm well organised. I'm off to see Brian tomorrow to see if he will be willing to sponsor my research in -----. Then Martin next week for -----. I hope they will help me to identify the best people or services to approach in my efforts to obtain and recruit suitable participants. Should I have undertaken an elective placement in rehab? Things might have been easier.

### ***29th October 1996 - "Identifying sources for research participants" "Challenging the medical model"***

Brian and Martin have been very supportive and both seem interested in the research and willing to help me recruit participants. The best way I think is to meet each of the community teams and present my research to them. I am feeling slightly concerned that it might be difficult to present the research to them in a succinct and professional way. This feels really important. I suppose I feel the psychiatrists might really question what I'm doing. I feel I might have some convincing to do. I must engage them without threatening their own views and beliefs. I feel like ignoring this for the time being - why am I doing this? Do I think the research is valuable? Yes I do, definitely. But the challenge feels a bit overwhelming at the moment.

### ***25th November 1996 - "Ethics and photocopying"***

I've submitted my project to the two ethics committees. I have never done so much photocopying. I do hope it gets through without having to do too many alterations; I've got so many interviews to do and I really need to get started as soon as possible. Will they let me interview this group? I now realise that I've chosen to study a group where particularly difficult ethical issues are raised. They are viewed as a particularly vulnerable group. Are they that vulnerable? Will they become overly distressed if I ask personal questions?

### ***28th November 1996 - "A challenge from social construction"***

I've just met with Steve Jones. He is on the ----- ethics committee. He feels the research will probably get through. However he has raised some really important questions for me. In fact I feel as if he has deconstructed my research project. I suppose I feel confused but enriched. What is the meaning of social support for this group? What does social support really mean? What are the alternatives for social support that might be important for this group? Are my research questions important for me or for the group I am investigating? Hopefully both.

### ***7th December 1996 - "The research is blocked"***

The first ethics committee have failed to approve my research! Help! I've rung Steve Jones to ask why. He was very apologetic. Apparently almost all the ethics committee were willing to approve the research with just minor changes. However, one member (who was a family member of one of the users of the service) did not agree with the others. Apparently she felt the research would be too distressing for this client group. Because she represented users views, Steve and the others decided they would have to support her decision. I will have to resubmit my proposal in March!

Is this research too distressing? I feel really disempowered. How can I answer the really important questions I think I have if I can't talk to the people concerned? If I can't ask people about the difficulties in their relationships how will we ever learn any more about them? Why did the research antagonise the one ethics committee member so much? When I'm feeling angry I begin to wonder whether it is because the research is asking questions about whether early experiences in the family have contributed to any of the clients current difficulties. Maybe she feels I am out to blame the family members of people with schizophrenia. Does the research threaten her? Alternatively, when I'm feeling low, I begin to wonder whether the research really might be too distressing for the people concerned. Are they too vulnerable?

I am going to ----- ethics committee in a few days to present myself in person and to argue the case for the research. It has got to get through or else my project is doomed. I'm desperately trying to ignore what this might mean for me and for my chances of qualifying on time. I'm off to meet Tony tomorrow evening for a strategy meeting and to talk about the best way of presenting the research. I must convince the ethics committee that the research is valuable and that my ethical procedures will protect the client group I want to interview.

### ***21st December - "The first project is abandoned"***

I suppose I'm feeling angry, frustrated and very low. Despite attending the ethics committee, and I think arguing my case well, the research committee have turned down my research. They gave three reasons. First, they questioned the value of my research. But were they judging the value of my research in an informed way? Are they right? Or are they just basing their judgements on the current discourse available to them? Are they blinded by the medical model to other alternative views and ways of explaining events? Second, they argued that some of my questions would be too distressing for the participants concerned. I'm left feeling confused about whether this is true or not. Third, they argued that my interview was too long. I agreed with them about this but told them that I would alter the interview length after having conducted a pilot study and asked the participants themselves about how they felt about the content and length of the interview. Fourth, they argued that the project was too big for me given my time-scale. I'm not sure whether ethics committees have a function to protect the well-being of the researcher although in some ways they are right. I was becoming extremely concerned that I would ever be able to finish the research on time. Still, I'm now going to have to start all over again. I can't bear to think more about this at the moment. I'm going to try to forget everything for the time being and have a decent Christmas break.

### ***12th January 1997 - "To a new methodology"***

I'm moving to a qualitative methodology. In many ways I think I should have started here anyway. It has a huge number of advantages. It will enable me to obtain the participants' own views of how things are for them. It will allow me to explore my research questions whilst basing the research in their views of reality. It will enable me to come to a much more complete understanding about the great myriad of factors which will impact on this group's ability to form relationships and utilise the support available to them. It will hopefully overcome the problems with ethics. The interviews will be shorter and participants will be able to tell me only what they want to. Also, I

will only need to interview approximately eight people in each group. It is depth of understanding and the complexity of the subject matter that matter in this methodology, not the numbers obtained. I am really excited at the idea of conducting this type of research. I may also qualify on time!

***25th January 1997 - "Conceptual and methodological issues"***

I am battling to fully understand the issues behind a qualitative paradigm. How will I be able to remain neutral during the course of this research and how can I take account of my own biases? I now feel I have a detailed understanding regarding the issues of reliability and validity in qualitative research. Yet I'm not sure they are as 'valid' as they appear. Does inter-rater reliability really mean anything when it is the meaning I give to the research that is important? Is respondent validity of value or will participants just agree with me anyway because of my powerful position? Is it ever really possible to be neutral when conducting research? As far as this latter question is concerned I really don't think so. I will inevitably impose my views and understanding on the research if it is to be anything more than descriptive. I suppose it is acknowledging as far as possible what influences my views that is important. I must make these open to others readers. I will also have to write up the research so that the reader can see every decision I have made and why. They must be given the material so that they can make their own alternative interpretations. Thank goodness I have written a research diary.

***1st February 1997 - "Confirming the appropriateness of the methodology"***

After two meetings, one with Dr Brian Solts and the other with Dr Mary Boyle, I feel confident about the research although nervous that I will ever finish on time. Both provided me with a range of new insights and the value of taking a qualitative approach has been reinforced. In particular I am going to include two new aspects. The first is to ask each group of participants about their views on what friends are for and the way they go about making friends. The second is to move away from the term 'social support'. After all, I don't talk about the 'social support' I receive from my relationships.

***3rd March 1997 - "Ethical approval is obtained"***  
***"Exhaustion"***

At last I have received ethical approval from both of the ethics committee. I have also applied to the ----- local research ethics committee. It has taken numerous meetings and a great deal of work to get to this stage and I haven't even begun the job of obtaining research participants. I have to hand in this research in four months time. Will I get it done? My level of anxiety is very high at the moment. It feels like I've got too many things to do all at once. And I feel completely exhausted and low. I'm beginning to wonder whether I should refer to next year just to take the pressure off. At least then I would feel less exhausted for my clinical work.

***15th April - "Frustration"***

I have now met with eight psychologists, four psychiatrists and the team members from two community wards (that's 14 meetings in total and each has taken an hour at least). Yet only one referral made to me so far. At least I have met the person. She is appropriate for the depressed group and is willing to participate. It is proving really difficult to obtain participants. The psychologists don't seem to be seeing people who

are depressed enough to score over 31 on the BDI. When they do, the psychologists have expressed concern that they might become overly distressed by the interview which means I cannot approach them. The psychiatrists have all expressed a willingness to support me despite some being apparently mystified by my methodology (I have spent a great deal of time trying to convince them of its value). Yet no referrals from them so far. I'm spending all my time at the moment on the phone trying to remind people about the research. I either get their secretaries and my calls are not returned, or the psychiatrists have been too busy (or have forgotten) to ask people who might be willing to participate. The community wards have been more helpful but it seems that everyone who has schizophrenia, and who is willing to participate, is also quite depressed. The most suitable people just don't seem to be willing to participate. Added to that, one day centre wasn't willing to help because too many people have conducted research there over the last few months and they feel their members need a break. I understand that but it's frustrating! And the ----- ethics committee want me to alter aspects of my research. I've started now in the other two regions and I can't have too different research projects going on at the same time!

Time is of the essence and everything feels out of my control. At least I have two good drafts done of my introduction and method sections. Will I be able to use them for anything? Perhaps I should submit an in depth qualitative account of the frustrations in clinical research! Would it pass?

### ***18th April 1997 - "Illness"***

Well at least I know now why I'm so tired. I've got a glandular virus (maybe glandular fever). I've had enough of everything and have decided that if I keep worrying about things then I will probably collapse from exhaustion. If I get the participants great, if not then I will finish it off next year.

### ***21st April 1997 - "The first interview"***

First interview done and it was very moving. I don't feel I need to alter the interview schedule in any way. I have two more interviews set up for next week. Suddenly I feel much more encouraged. Yes the research is valuable and people are coming forward. The participant herself thought the interview was revealing and helpful in that it brought up things she had not thought about before. Yet she was not 'messed up' by it. If I could get five people from each group then I might get something of value. I have renewed my efforts to obtain participants. I have reminded everyone yet again and have arranged four new meetings, two with psychiatrists and two with the multi-disciplinary teams in two day centres. Maybe these will be more productive.

### ***3rd May 1997 - "Things get moving"***

At last, people who are really keen on the project and who are making really active efforts to help me recruit participants. It finally seems as if I have met people who have a social or psychological way of viewing mental illness. The two day centres have been a particularly useful source. I have met a number of potential participants, many of whom are suitable for the research. I have now done four interviews. It feels too early to see any common themes emerging although it seems to feel very different personally when I am with a member of the depressed group compared to when I am with a member of the schizophrenic group. The meetings with the depressed group feel deeper and more real. I wonder why I feel that?

### ***15th May 1997 - "Things are moving"***

Half my interviews are now completed and I'm beginning to make active efforts to match the two groups of participants. It seems difficult to find males for the depressed group. The interviews have gone well. No-one has become overly distressed. In fact, no-one in the schizophrenic group have become distressed at all. I'm feeling too overwhelmed by the amount of content in each interview to be able to take a step back and form preliminary ideas about what differences are emerging. In fact in a recent meeting with Tony I found it difficult to remember which group had said what. Maybe things will become clearer as I begin the analysis.

### ***23rd May 1997 - "The analysis"***

Some time off placement has given me the chance to begin analysing my interviews at a gentle and slow pace. Things are beginning to feel as if they are now under my control and I'm definitely feeling less anxious as a result. I feel somewhat overwhelmed by the amount of data I have generated just from the first two interviews. I am attempting to keep the first stages of the analysis as close to the actual data as possible. The codes are very similar to what the participants actually said. In fact my attempts to describe these codes more creatively has only resulted in confusion and I have decided to return to the originals. The categories that are emerging appear really interesting. With any luck themes will emerge as I continue with this process. I am very tired having spent every hour of the day for the last three weeks transcribing the interviews. What would it have been like if I had taped them!

### ***8th June 1997 - "Completing the interviews"***

At last everything is under my control. I have interviewed eight participants in each group and they are closely matched on age, gender, educational achievement and so on. The interviews have been moving, interesting and revealing and there will be a great deal to talk about in discussing this research. I am feeling really positive about what I have done and it is all beginning to feel worthwhile. I still feel very immersed in the data developed - I have 150 pages of it already. A meeting with Tony has helped me to re-prioritise what I am looking for and I am going to re-immers myself in the interviews again.

### ***25th June 1997 - "Developing the themes"***

I have just met with Tony and feel excited at the themes that are emerging from the research. I think it will lead to an interesting and revealing theoretical framework. I now feel less lost although feel some regret at the fact that I will not have enough room in the project (the limit is 20,000 words) to include all the themes and ideas that have emerged out of it. Whilst I feel that my themes are grounded in the actual data I am going to go back over all the interviews to re-assess everything. I'm beginning to write up the results section. I am finding it difficult to work out how to present the results so that they are accessible to the reader (and so the reader can understand the steps I have taken) without taking up too many words.

### ***1st July 1997 - "Developing the theoretical framework"***

At last everything is coming together. I have a meeting with Tony to review my initial attempts at imposing a theoretical framework on the data. Will it make sense to him? I am also in the process of conducting the inter-rater reliability study and have begun



planning the respondent validity interviews (although I remain somewhat doubtful about the real value of either).

***13th July 1997 - "My first day off"***

I had my first day off from working yesterday for a long time. I hope it will give me some space to look at things with a new eye and to make alterations where necessary. Lots of work to do, but with a two week extension, I will get it in on time.

***14th July 1997 - "A coming together"***

Tony has been enormously helpful and supportive. He appears excited at the theoretical framework that has been developed and has made a number of useful suggestions regarding how I write up the research. I suppose because of our mutual excitement and interest Tony thought it would be useful to have a neutral person read through the research to ensure that the theoretical developments have not moved too far from the data. Dr Margie Callanan has kindly agreed.

***26th July 1997 - "Finishing"***

My last entry. I've finished and I'm feeling pleased with what I've accomplished. All I can really think about is what I'm going to do in my time off.

## **APPENDIX 10**

**Tables 3-13: The Categories Generated from Participants' Responses to Each Research Question**

## **The Categories Generated for Participants' Responses to Each Research**

### **Question: Tables 3-13**

Each table contains the categories generated from participants' responses to each research question. The number presented after each category refers to the number of participants who gave a response in the interview that could be included in the category.

**Table 3. The categories generated for participants' views about what friends are for**

Group S	Group D
1. Companionship (5)	1. Companionship (6)
2. Talking and sharing thoughts (3)	2. Talking and sharing thoughts (1)
3. Emotional support (2)	3. Emotional support (6)
4. Practical support (5)	4. Practical support (1)
5. Having fun with (1)	5. Having fun with (2)
	6. Friends do not exist (1)

**Table 4. The categories generated for participants' views about the way they made friends**

Group S	Group D
1. No difficulties reported (3)	2. No active efforts made (6)
2. No active efforts made (1)	4. By joining clubs or societies (2)
3. Through conversation (5)	5. Difficulties reported:-
4. By joining clubs/societies (1)	a) Negative reactions (stigma) from the general population (3)
5. Difficulties reported:-	d) Not trusting other people with mental health problems (3)
a) Negative reactions (stigma) from the general population (3)	e) Lack of trust in people in general (3)
b) Too many needs or emotions expressed by people with mental health problems (2)	f) Would rather avoid people (3)
c) Fear of the general community (1)	

**Table 5. The categories generated for the interpersonal problems reported by the participants**

Group S	Group D
1. No difficulties reported (2)	2. Unable to form relationships with people (4)
2. Unable to form relationships with people (4)	3. Negative reactions from others (2)
3. Negative reactions from others (4)	5. Preference is to be alone (2)
4. People get too close (3)	7. Not fitting into society (1)
5. Preference is to be alone (2)	8. Negative effects of symptoms (1)
6. Lack of assertiveness (1)	10. Others take advantage (4)
7. Not fitting into society (1)	11. Don't believe people are trustworthy (6)
8. Negative effects of symptoms (3)	12. Need to protect oneself (5)
9. Dislike contact with people expressing negative emotion (2)	13. Overly critical of people (1)
	14. Helplessness (1)
	15. Low self esteem (1)
	16. A dislike of social rules (1)

**Table 6. The categories generated for participants' explanations for their interpersonal problems**

Group S	Group D
1. No interpersonal problems reported (2)	1. No interpersonal problems reported (1)
2. Lack of social skills (6)	2. Lack of social skills (1)
3. Find it difficult to meet people's needs (2)	5. Negative effects of symptoms (1)
4. No opportunity to meet people (2)	8. Low self-esteem (1)
5. Negative effects of symptoms (2)	10. Others fail me or are untrustworthy (2)
6. Trust in people has gone (1)	11. Negative experiences of early relationships (3)
7. Stigma and negative reactions from people outside mental health services (1)	12. Lack of assertiveness (3)
8. Low self-esteem (1)	

**Table 7. The categories generated for participants' early experiences with family and friends**

	Group S	Group D
Early experiences with the family	1. Positive comments (6) 2. Negative comments (3):- a) <i>Lack of personal control</i> (2) b) <i>Felt alone in the family</i> (1) c) <i>Few memories</i> (1)	1. Positive comments (2) 2. Negative comments (6):- a) <i>Lack of personal control</i> (5) b) <i>Felt alone in the family</i> (3) d) <i>Little emotional contact</i> (5) e) <i>Negative emotional contact</i> (1) f) <i>Anger expressed about early upbringing</i> (3)
Early experiences with friends at school	1. Positive comments (2) 3. Negative comments (6):- a) <i>Teased or bullied</i> (6) b) <i>Difficult</i> (4) c) <i>Lonely at school</i> (6)	1. Positive comments (3) 2. Mixed comments (2) 3. Negative comments (3):- a) <i>Teased or bullied</i> (1) c) <i>Lonely at school</i> (2)

**Table 8. The categories generated for how the onset of the participants emotional difficulties impacted on their relationships**

Group S	Group D
1. Isolation (5)	1. Isolation (6)
2. Resentment expressed at others (5)	2. Resentment expressed at others (1)
3. Resentment experienced from others (1)	3. Resentment experienced from others (1)
	4. Personal shame (3)
	5. A loss of assertiveness (1)

**Table 9. The categories generated to participant descriptions of their current relationships in the family**

	Group S	Group D
General comments about the family	1. A close family (5) 2. Negative or hostile feelings expressed towards the participant (3)	3. Feel shameful (2) 4. Not understood by family (3) 5. No present contact with family (2) 6. Difficult to maintain contact (1)
Activities done with the closest member	7. Talking (4) 8. Practical activities (7) 9. Practical help (2)	7. Talking (4) 10. None (3)
Feelings associated with being with that person	11. General positive comments (4) 12. Practical descriptions of the person (4)	11. General positive comments (4) 13. Positive emotions expressed towards the person (4) 14. No contact wanted (1)
What is gained from the relationship	15. Nothing (2) 16. Practical support (5) 17. Emotional support (1)	15. Nothing (1) 16. Practical support (2) 17. Emotional support (5)
What are the negative aspects of the relationship	18. None (5) 19. Not given enough independence (2) 20. Do not trust person (1)	18. None (1) 21. Don't receive enough support (4) 22. Loss of self-esteem (3)
The discrepancy between the actual and ideal levels of support received in the relationship	23. Contact appropriate (5) 24. Would like more (3):- <i>a) lack of contact explained as being due to external, practical factors (3)</i>	23. Contact appropriate (2) 24. Would like more (5):- <i>a) lack of contact explained as being due to external, practical factors (1)</i> <i>b) 'fault' with the family member (2)</i> <i>c) 'fault with the participant (1)</i>
Researcher's impressions of the participants' comments	25. Lack of emotional content (6) 26. 'Normal' description (2) 27. Clear lack of independence (2)	28. No contact (2) 29. Clearly wants more support (5) <i>a) cannot ask for more (1)</i> <i>b) family members will not provide more (3)</i> 30. Shame (1)

**Table 10. The categories generated to participant descriptions of their current relationships with friends**

	Group S	Group D
General comments about the participants' friendships	1. Suspicious people will take advantage (5) 2. Best to remain apart (2) 3. Negative reactions from others (1) 4. Lost contact since the start of the emotional difficulties (1) 5. Expressed desire for more contact with people (1)	6. No friends reported (3) 7. Not feeling worthy of friends (1) 8. Avoidance of people with mental health problems (1) 9. Positive experiences with friends (2) 10. Difficulty maintaining relationships (1)
Where the friendship was formed	11. Long term friend (2) 12. Mental health services (6)	11. Long term friend (2) 12. Mental health services (2) 13. More recent friendship formed outside mental health services (1) 14. No friendships reported (3)
Feelings associated with being with that person	15. General positive comments (7) 16. Feeling of inferiority (1)	15. General positive comments (4) 16. Feeling of inferiority (1) 17. Emotional support (1)
What is gained from the relationship	18. Emotional support (2) 19. Companionship (4) 20. Practical support (2) 21. Having a laugh (1)	18. Emotional support (5) 21. Having a laugh (1)
What are the negative aspects of the relationship	22. Nothing (2) 23. Lack of contact (2) 24. Friend's mental health problems (2) 25. One-sided relationships (2)	22. Nothing (1) 24. Friend's mental health problems (2) 25. One-sided relationships (2) 26. Friend being dominant/loss of self esteem (2) 27. Afraid of asking for too much (2)
The discrepancy between the actual and ideal levels of support received in the relationship	28. None (5) 29. Would like more support (2):- a) Practical/practical reasons for the discrepancy (2) 30. Would like less support (1)	29. Would like more support (3) a) Practical/practical reasons for the discrepancy (1) b) Can't lean too much on the person (2) 31. No friendships (3) 32. Mixed feelings (2)

**Table 11. The categories generated to participant descriptions about their current relationships with mental health professionals**

	Group S	Group D
General comments about professionals	1. Generally positive (6) 2. Generally negative (2):- <i>a) Not close to staff (2)</i>	1. Generally positive (3) 2. Generally negative (5):- <i>a) Not close to staff (4)</i> <i>b) Don't receive enough support (3)</i> <i>c) Staff not interested in patients (3)</i> <i>d) Support difficult to access (2)</i> <i>e) Smothering (1)</i> <i>f) Staff need more training (1)</i>
Amount of contact with the closest professional	3. No close professional (1) 4. Once a month (1) 5. Every other day (4) 6. Every day (2)	3. No close professional (4) 7. When needed (2) 8. Once a week (2)
Activities done with the professional	9. Emotional support (4) 10. Practical support (3)	9. Emotional support (4)
What is gained from the relationship	11. Practical support (4) 12. Emotional support (4)	11. Practical support (1) 12. Emotional support (4) 13. Fun (1)
What are the negative aspects of the relationship	14. Nothing (5) 15. Not enough contact (1)	14. Nothing (1) 15. Not enough contact (3) 16. No professional close (4)
The discrepancy between the actual and ideal levels of support received in the relationship	17. None (5) 18. Would like more (1):- <i>a) but person too busy (1)</i>	17. None (2) 18. Would like more (2):- <i>a) but person is too busy (1)</i> <i>b) have to share person with others 1</i>

**Table 12. The categories generated for the inter-relationship between the participants' emotional difficulties and their relationships with others**

	Group S	Group D
Participants' explanations for their interpersonal difficulties	1. A disease/biological in origin (1) 2. Biological with the influence of simultaneous life events not acknowledged (3) 3. A combination of biological and life events (1) 4. In the mind (1) 5. Life events only (2) <u>Life events reported :-</u> a) Non-personal (2) i) <i>Spiritualist activities (1)</i> ii) <i>Work stress (1)</i> b) Personal (2) i) <i>Loneliness (2)</i> ii) <i>Not obtaining a partner (2)</i> iii) <i>A violent attack (1)</i> iv) <i>Stress at home (1)</i>	2. Biological with the influence of simultaneous life events not acknowledged (1) 3. A combination of biological and life events (1) 5. Life events only (6) <u>Life events reported</u> a) Non-personal ii) <i>Work stress (1)</i> iii) <i>Excessive drug use (1)</i> b) Personal i) <i>Loneliness (2)</i> iii) <i>A violent attack (1)</i> v) <i>Emotional neglect in early life(5)</i> vi) <i>A lack of personal control (4)</i> vii) <i>Bereavement (2)</i>
The impact of relationship difficulties on the participants' emotional problems or symptoms	6. No impact (3) 7. Difficulties in forming relationships (4) 8. Loneliness (1) 9. Too much contact with people (2) 10. Other's problems contributes to symptoms (1)	6. No impact (1) 10. Other's problems contributes to symptoms (1) 12. Negative experiences in the family (6):- a) <i>Lack of personal control (2)</i> b) <i>Emotional neglect (3)</i> c) <i>Loneliness</i> 13. Negative reactions from others 1 14. Bereavement (2)
The impact of the participants' emotional difficulties or symptoms on their relationships with others	16. Generally negative (4):- a) <i>Negative effects of symptoms (4)</i> b) <i>Negative reactions from others(2)</i> c) <i>Forced separation from others (2)</i> 17. Generally positive (4):- a) <i>More contact with people than before (4)</i>	15. Never had real relationships (2) 16. Generally negative (6):- a) <i>Negative effects of symptoms (4)</i> b) <i>Negative reactions of others (3)</i> d) <i>Results in social withdrawal (3)</i> e) <i>Feel stupid (2)</i> f) <i>Stuck in mental health services 1</i>



**Table 13. The categories generated for participants' desired changes to their social relationships and their views about how services could be changed or modified to meet their social needs more adequately**

	Group S	Group D
Desired changes in their relationships with others	<ul style="list-style-type: none"> <li>1. No changes desired (3)</li> <li>2. No longer experience symptoms (4)</li> <li>3. Be more sociable (2)</li> <li>4. Have more relationships (4)</li> <li>5. Changes not to do with relationships or illness (3)</li> </ul>	<ul style="list-style-type: none"> <li>1. No changes desired (1)</li> <li>2. No longer experience symptoms (1)</li> <li>6. Form closer relationships (3)</li> <li>7. Obtain a sexual partner (2)</li> <li>8. Specific changes in relating to people (3)</li> <li>9. Increased assertiveness (2)</li> <li>10. Change early family relationships (2)</li> <li>11. Eliminate shame (1)</li> <li>12. Receive no more abuse from strangers (1)</li> <li>13. Have a job/goals in life (2)</li> </ul>
Desired changes in service provision	<ul style="list-style-type: none"> <li>14. General satisfaction expressed (6)</li> <li>15. General disillusionment (1)</li> <li>16. More contact/support wanted from staff (4)</li> <li>17. More contact wanted from specific professionals (3)</li> <li>18. Changes in staff attitudes or training (3)</li> <li>19. More activities (2)</li> <li>20. Social skills training (1)</li> <li>21. Get me better (3)</li> <li>22. Less crowded services (2)</li> </ul>	<ul style="list-style-type: none"> <li>14. General satisfaction expressed (1)</li> <li>15. General disillusionment (3)</li> <li>16. More contact/support wanted from staff (5)</li> <li>17. More contact with specific professionals (1)</li> <li>19. More activities (1)</li> <li>20. Social skills training (1)</li> <li>23. Improved service organisation (5)</li> </ul>

## **APPENDIX 11**

The codes and categories generated from participants' responses to each research question

### **OUTLINE**

Detailed information regarding the codes and categories generated from participants' responses to the research questions is presented here. The categories generated to each research question are underlined with the codes subsumed under each category presented below it. Exemplary quotations are used to illustrate certain codes. The number following each category or code refers to the number of participants in that group who gave a response which could be included in the category or code.

## QUALITATIVE ANALYSIS: SCHIZOPHRENIC GROUP

### RESPONSES TO RESEARCH QUESTIONS

#### 1. Participant views about what friends are for

Talking and sharing thoughts 3

Companionship 5

Doing things together 3

Stop you being alone 1

To keep in contact with 1

Company 2

Have fun with 1

Have a laugh 1

Emotional support 2

To appreciate you 1

To confide in 1

Non-emotional support 5

The sharing of assets 2

The giving of practical support when in trouble (e.g. a fight) 1

*"after all a friend in need is a friend indeed".*

To be helpful in practical ways 2

To give you things 1

To exchange information 1

#### 2. Participant views about the way they go about making friends

No difficulties reported

No difficulties 3

No active efforts made 1

Sometimes not worth bothering 1

People must approach me 1

Through conversation 5

People talk to each other 2

Showing someone around at work 1

Strike up a conversation 3

*"You talk to them. It's like a gradual, graded process".*

By joining clubs/societies 1

## Difficulties reported

### Too many needs or emotions expressed by people with mental health problems 2

Difficult because people's needs are so dire 1

### Negative reactions (stigma) from the general population 3

People with mental health problems are made to be a sub-class of people 2

*"it's like people at —, they are a different class of people. They don't understand people with mental health problems".*

### Fear of the general community 1

Suspicious of people outside mental health services 1

*"people outside are different. They have never had psychiatric drugs. Many of them are wild and out of control. Our minds have been conditioned by drugs so we are mentally stronger. Outside there is loads of violence".*

## 3. The interpersonal problems reported by the participants

### No difficulties reported 2

### Feel people get too close 3

Having too little privacy 1

Too many people around (e.g. holiday crowds) 2

People want to get too close 1

Important to keep people at arms length 1

### Negative reactions from others 4

People have the wrong impression of people with mental health problems 2

*"people think we are nasty but actually we are reasonable, nice people".*

Avoids people outside services 3

Few people really want to be around me 2

### Unable to form relationships with people 4

Unable to forming relationships with the opposite sex 2

Too nervous or shy to meet new people 2

Feel I have to mind my own business 1

### Preference is to be alone

Being a bit of a loner 2

### Lack of assertiveness 1

Giving in to people's demands e.g. for cigarettes 1

*"I always give away too much. I suppose I'm frightened if I don't, maybe they might hit me. If I didn't back off we might fight to the death".*

People want to use you 1

### Not fitting into society 1

*"You have to be one of the crowd or else you are an outcast".*

### Negative effects of symptoms 3

#### Physical

Negative effects of physical symptoms 1

*"Because I shake so much people look at me and think I'm a loony, a head banger, a woozy".*

#### Cognitive

When not in reality can't talk to people 2

#### Paranoia

Suspiciousness and paranoia prevent contact with people 1

Feel strange people are out to hurt me 2

*"people out there are uncontrolled".*

Dislike contact with people expressing negative emotion 2

### 4. Participants' explanations for their interpersonal problems

No interpersonal problems reported 2

#### Lack of social skills 6

No longer know how to socialise 1

*"its been so long since I've been to a party that I've forgotten what to do".*

Don't know what to say to people 1

*"it's like the conversation just drops".*

Don't understand the opposite sex 1

Do not have the social skills/education to mix with people 3

*"because I'm not educated properly I don't know how to talk to different classes of people. Its difficult then to meet other people". "If you get to be more intelligent then you can break the class barrier".*

Find it difficult to meet people's needs 2

No opportunity to meet people 2

No opportunities to meet people outside mental health services 1

No opportunities to meet people 1

#### Negative effects of symptoms 2

Voices confuse and undermine me 1

As a result of mental health problems 1

Trust in people has gone 1

Stigma and negative reactions from people outside 1

Low self esteem

A bad physical appearance 1

### 5. Participants' early experiences with family and friends

#### *a) Family*

Positive comments 6

OK 4

A happy family 4

Good memories 3

Brought up by grandparents - mother left at age three - a good upbringing though 1

Negative comments 3

Lack of personal control 2

Not enough independence from mother 1

Disturbing marital arguments 1

*"I became too frightened to see what was going on. The rows were really bad and I never knew what to do".*

Felt alone in the family 1

Left to look after myself 1

Few memories 1

Wasn't good but I can't remember anything 1 (wanting to avoid topic)

**b) School**

Generally positive comments 2

Happy 2

Several friends 2

Generally negative comments 6

Teased or bullied 6

Was picked on/bullied 4

Teased a lot 4

*"they used to call me a swot or tease me for being weak and pathetic".*

Difficult 4

Lonely at school 6

Missed out on social interaction 2

Lonely/few friends 4

Never really talked to people 1

**6. How the onset of the participants emotional difficulties impacted on their relationships**

Isolation 4

No-one understood 1

I couldn't tell people 1

*"nobody really understood at the time and I decided I couldn't tell people". "I felt so worried that people would attack me that I just stayed inside all day. I just slept".*

Couldn't cope with society 3

Forgot to look after myself so people didn't want to be near me 1

Resentment expressed at others 5

People treated me like shit 1

Forced to leave home 3

People no longer trusted me to look after kids 1

People thought I was bad or no good 1

Resentment experienced from others

People became angry 1

**7. Describing Current Relationships in the Family**

Negative or hostile feelings expressed towards participant 3

Difficulty with one member who alienates person from the rest of the family 1

People very abrupt 1

People do not talk to me 1

Close 5

**8. The Family (closest member)**

*person:-*           mum 6  
                          brother 1  
                          dad 1

***a) Level of contact***

Primary contact via phones or letters 1

Once every six months 1

Once a month 2

Once or twice a week 3

Every day 1

***b) Activities***

Talking 4

Phone conversations 2

Talk about things that are not too personal 2

Practical activities 7

Practical activities e.g. shopping 5

Go out together e.g. for coffee 1

Have family meals 3

Non-emotional help 2

Go to her if in practical trouble of any sort 1

I give him money 1

**c) Feelings associated with being with the person**

Non-emotional descriptions of person 4

*"she's got brilliant taste you see and an immaculate home". "Fantastic, she does my cooking and washing. She makes me my bed though and forces me to change my underwear".*

General positive comments 4

Nice/pleasant 3

Its OK 1

She brings back fond memories 1

**d) What is gained from the relationship/support received**

Non-emotional support 5

Help with practical problems 5

*"she deals with my cheques and bank details and things".*

I go to her when I'm in any sort of trouble 1

Nothing 2

Nothing specific mentioned 1

Nothing, client supports member of family 1

Emotional support 1

*"she says encouraging things".*

**e) What are the negative aspects of the relationship**

None 5

None (disappointments rationalised) 2

None 3

Not given enough independence 2

Not given enough independence 2

*"I suppose its that she sometimes treats me like a child. Sometimes she tries to take over my life. Sometimes I ring her for a quick call and it takes over an hour".*

Do not trust the person 1

Does not trust person with personal information 1

Other 2

She doesn't know me as well as she thinks she does 1

Don't like person's partner 1

**f) Circumstances in which support is accessed**

Only when it will not make the family member too upset 1

Cope on my own/ cope on my own more now 2

When needed/when in trouble 3

Not accessed 2



All the time 1

**g) The discrepancy between actual and ideal levels of support**

Would like more 3

Lack of contact explained as being due to external, non-emotional factors 3

Too old to visit me 1

Can't expect too much 1

Too ill 1

She gets sad, has a lot to cope with 1

*"I probably shouldn't phone her sometimes, say if I'm upset, because it will only upset her. She has all that worry after all".*

Difficult for her to see me 2

*"she works five days a week you see so she can't see me more".*

She does not have enough money to see me 1

He doesn't have any money to give me 1

Contact appropriate 5

Want/have my own independence 3

**1) Researcher's thoughts**

Lack of emotional content 6

Description of person in non-emotional ways 4

*"she had a good memory". "she's very intelligent".*

Felt that lack of contact was rationalised to protect the other person 2

Appeared that participant was unwilling to reveal hostile feelings despite difficult episodes reported 2

Support interpreted purely as financial/practical support despite prompts 3

Practical support the only support wanted 3

'Normal' description 2

Lack of independence from family member 2

**9. Describing Current Relationships with Friends**

Suspicious people will take advantage 5

Hard to find true close friends 3

*"you only know your true friends when you are in need". "Its difficult to know whether people are true friends or not".*

Friends always after things 2

*"its like, well friends are always on the tap here. They are always scrounging, always want money".*

Best to remain apart 2

*"it's a quagmire. It's best to remain apart; it's difficult to help if you haven't got what they want".*

People have unmet needs 1

*"people's needs are so dire, more dire than can be given by me at the time".*

Negative reactions from others 1

*"Most people do not want to know me".*

Lost contact since emotional difficulties began 1

*"Used to have a good time before my mental health problems".*

Expressed desire for more contact with people 1

### **10. Friends (closest member)**

No friendships reported 0

Long term friend formed outside mental health services/not seen regularly 2

More recent friendship formed outside mental health services 0

Sexual partner formed within mental health services 0

Friendship formed within mental health services 6

#### ***a) Level of contact***

Sends letters, receives letters less frequently 1

Long term friend, but see infrequently (once every three months) 1

Every week 1

Every other day 2

New friend, see three to four times a week 1

Every other day 1

Most days 1

#### ***b) Activities***

Social activities

Play snooker/scrabble/chess 2

Go out for drinks/social events 3

Going out during the day 3

Holidays 1

Receiving letters 1

Working together 1

Sexual contact 1

#### ***c) Feelings associated with being with the person***

General positive comments

She is very nice 1

It's good 4

I like people with strong views 1

Makes me feel really great when I receive a letter from her 1

Its fun/we have a laugh 4  
Understand where each other is coming from 1  
Company but can be boring 1

Feeling of inferiority 1

Sometimes person talks a great deal and I find it difficult to say things 1

**d) What is gained from the relationship/ type of support received**

Emotional support 2

*"I write to her when I'm up and when I'm down. She is all purpose like a J-cloth- although I would never put her in a washing machine. Actually she is more like a teddy bear, someone you can cuddle".*

Self esteem 1

*"it's good to be appreciated by a woman again. She praises me and believes in me".*

Companionship 4

Someone to talk to when things are difficult 1

Non-emotional support 2

Helped with practical difficulties 1

Something to do 1

Advice about voices 1

Having a laugh 1

**e) What are the negative aspects of the relationship**

Lack of contact 2

None, but would like to see more 2

Friend's mental health problems 2

Don't understand her when she is ill 1

*"she claims that someone else has got her real children. I don't understand why she does that".*

He has mental health problems 1

One-sided relationships 2

Scrounges off me 2

Nothing 2

Other

Rather best friend was a woman 1

Sexual problems 1

Friend unreliable 1

Friend boring 1

**f) Circumstances in which support is accessed**

Continual support 1

When he visits 1  
When things are difficult 1  
Don't know person well enough yet 1  
Not really accessed 2  
When I need it 1

***g) The discrepancy between actual and ideal levels of support***

Would like more 2

***Practical/non-emotional reasons for the discrepancy*** 2

He/she has a lot to do 2  
*"she is a single mum you see".*  
People have their own lives to get on with 1  
Can't expect more 1  
Would rather have a girlfriend 1

None 5

More would be suffocating 1

Would like less 1

*"its boring really, I don't really learn anything off him. I don't improve my mind".*

***h) Researcher's impressions***

Lack of contact rationalised to protect the other person 2  
My own sadness at idealisation of support when little appears to be received in reality 3  
'Normal' description of relationships 1  
Primarily appears to be a social contact in the day centre 3  
Dissatisfied with number/amount of contact with friends 2

**11. Describing Current Relationships with Professionals**

Generally negative 2

***Not close to staff***

I don't feel close to any 2  
Don't go to day support 1  
*"all those people have given up you see. It's depressing to be around all those psychiatric patients. So I don't talk to them. The voices make me feel bad when I'm there. I'd rather have normal friends".*

Generally positive 6

They are really nice generally 2  
Get good support 5

## **12. Professionals (closest member)**

### ***a) Level of contact***

Every day 2  
Every other day 4  
Once a month 1  
No close professional 1

### ***b) Activities***

#### **Emotional support**

Talking about difficulties 3

A range 1

*"anything from the sublime to the ridiculous".*

#### **Practical support**

Playing snooker 1

Giving injections 1

Giving medication 1

### ***c) Feelings associated with being with the person***

#### **Supportive 4**

*"he always asks how you are even if he is feeling down". "I see him if I'm upset".*

#### **Fun 1**

#### **No feelings 1**

#### **Other**

Like a father/mother figure 1

Everyone likes him 1

### ***d) What is gained from the relationship/ type of support received***

#### **Non-emotional support 4**

Cutting nails 1

Doing fun activities 1

Monitors my condition 1

Given medication 1

Talk when have practical difficulties 2

#### **Emotional support 4**

Talk to when feeling low/upset 3

Talk when I'm agitated 1

*"he's the only person who can get me back down to earth when I'm in a temper".*

### ***e) What are the negative aspects of the relationship***

**Nothing 5**

Not enough contact 1

Person can be too busy with other things 1

Other

Can't get angry with him 1

***f) Circumstances in which support is accessed***

Anytime when he/she is around 2

When things are difficult 3

Support not really accessed 1

In appointments 1

***g) The discrepancy between actual and ideal levels of support***

None 5

It would get a bit much 1

Would like more 1

Person sometimes too busy 1

**13. Participants' views about the cause of their emotional difficulties or symptoms**

A disease/biological in origin 1

*"it comes from within the mind, like mind over matter, a disease I suppose".*

In the mind 1

*"its inner speech that comes from not thinking properly. When you don't use your mind the voices take over. The voices then tell you that you must get your thinking straight. It happens to me because I've got a weak personality. It's from childhood I think. I was lazy you see, even when I was about three to five and I didn't learn to use my mind properly. It means I've got a weak personality. If I was mentally stronger then I wouldn't get the voices".*

Biological with the influence of simultaneous life events not acknowledged 3

Father's illness 1

*"it started first when my dad was really ill".*

Birth of child 1

*"The voices got nasty after the birth of my second child. I didn't realise that I was ill. I think it happened though because my head didn't form properly. My doctor told me that it had formed lopsided. That's why I hear voices".*

Being forced out of home and abandoned by parents 1

Combination of biological and life events 1

(life event details included below)

## Life events: 2

### a) non-personal

Spiritualist activities - voices and visions 1

Work stress 1

Studying too hard 1

*"its like I forced myself to study tilt four in the morning. The pressure came from my insecurity and whether I would get good enough marks to go to university. In the end I just burnt out".*

### b) Personal

Violent attack 1

A murder in the family 1

Stress at home 1

Not obtaining a partner 2

Stress of never having had a girlfriend 2

Not understanding how to get a girlfriend 2

Loneliness 2

Loneliness and isolation 2

Cramped in a small bed-sit, not going out, not eating 1

*"I didn't say hello to anyone for about three years".*

### c) Other

Thought voices were normal at first 1

*"I first heard voices as young as two I think. I did not question it you see. You can't really read people's minds so you don't know what other people are experiencing do you. If you think its normal you don't question it. I used to play with the voices".*

Paranoid rationale 2

*"they started because I could no longer put the signs on the TV".*

## 14. Participants' views about whether relationship difficulties contributed to their emotional difficulties or symptoms

### No impact 3

No, yet acknowledgement that relationships can make person feel worse 1

*"But it was the voices that made me upset. Dad dying just made me feel worse".*

### Difficulties in forming relationships 4

Always found it difficult to make friends 1

No relationships/difficulties forming relationships with sexual partners 2

*"it was really difficult to get a girlfriend you see. I just didn't know how".*

Because very sensitive/shy 1

### Loneliness 1

Extreme loneliness and isolation therefore got lost in a dream 1

### Too much contact with people 2

Being with too many people brings on symptoms 2

*"when I'm in a group it can make me feel very paranoid. I just have to walk away for a bit and come back when it's less busy".*

Other's problems contributes to symptoms 1.

Other

Family murder the cause 1

Because intimidated by others 1

Don't know what to do to make things better 1

**15. Participants' views about whether their emotional problems or symptoms had changed their relationships with other people**

Generally Negative 4

Negative effects of symptoms 4

Voices - Don't feel normal - bad about myself - unconfident 3

Symptoms affect other people 3

*"its like when I get strange it's difficult for —"*.

Negative reactions of others 3

Social stigma of mental health services - people no longer want contact 2

*"people don't really want to know people who are having difficulties"*.

Forced separation from others 2

Split up from husband 1

Separated from children 1

Mental health problems mean I've lost all my friends 1

Other

Don't tell people about problems 1

Met 'bad' people in mental health services 2

Generally Positive 4

More contact with people in mental health services than before 4

Made friends/partner in hospitals and clubs 3

*"I met — in hospital. If it wasn't for her I'd be dead now probably"*.

People in hospital understand and are supportive 1

Done far more with people since the illness 1

Much less lonely 1

**16. Participants' views about how they would like their social relationships to be different**

No changes desired 3

I'm improving steadily

No longer experience symptoms 4

I would get rid of this illness/voices 3

*"people know I'm a cretin just by looking at me, my dress, my speech, how I walk and that. People can see I've got problems. And because I like to be honest I admit it to people"*.



Get rid of malevolent unconscious 1

Be more sociable 2

More chatty 1

I would socialise more 1

Be able to give to other people 1

Have more relationships 4

Have a girlfriend/boyfriend or a wife/husband 2

Have a companion 1

Not be lonely in my flat 1

Less bored 1

Changes not to do with relationships or illness 3

Become more intelligent 1

Have more money 1

If I started windsurfing 1

If I became a private detective 1

**17. Desired changes in service provision**

General satisfaction expressed 6

More contact/support wanted from staff 4

Staff should be more supportive 2

More continuous care 1

*"its like people move and then lose track of the plot".*

More continuous support from the psychiatrist 1

More contact from staff 2

*"it would be nice if the staff came out of the office and mingled with the crowd".*

More contact with specific professionals 3

More OT 2

I would like counselling 1

*"to sort things that crop up in my mind".*

I would like a CPN 1

*"even if he only gives me a ring every now and again".*

Change in staff attitudes/training 3

Staff should believe you more 1

Staff should be more carefully selected 1

Staff should be more strictly monitored 1

Easier ways for patients to make complaints against staff 1

Staff expecting less of you 1

Insist husband takes tablets 1

Staff maintain more disciplined confidentiality 1

More activities 2

Something to do in the evening 1

Get a job 1

More services so people have things that they can do during the day 2

*"it would take away the boredom and allow me to do interesting things".*

Social skills training 2

*"teach me about how to make more conversations".*

General disillusionment (1)

Not much to be done 1

*"with no money, no status and no job there isn't much point in trying anything. I couldn't handle the handle".*

Get me better 3

Move out of hospital 1

Get back on my feet again - staff wouldn't have to look after me as much then 1

Get better 2

*"things will never be as good when I'm unwell".*

Find my own flat 1

Less crowded services

Less crowded services 1

People in hospital should have their own, separate rooms 1

## **QUALITATIVE ANALYSIS: DEPRESSED GROUP**

### **RESPONSES TO RESEARCH QUESTIONS**

#### **1. Participant views about what friends are for**

Talking and sharing thoughts 1

Companionship 6

Company 3

*"with people who appreciate the same things like music. Its someone to sit with and do those sorts of things with".*

Someone you can feel comfortable being with 1

To share similar interests together 1

Someone who can be with you even when you are low 2

Emotional support 6

Someone to talk to when you are low 1

Someone who cares about you and means it 3

Someone who's advice and support you respect 1

Someone to spill your troubles out to 2

Moral support 1

To cheer you up 1

Non-emotional support 1

A helping hand 1

True friends no longer exist 1

Having fun with 2

Make you laugh 2

## **2. Participant views about the way they go about making friends**

No active efforts made 6

Takes a long time, no point in being particularly active 1

I usually want to be alone 2

It's not worth bothering 2

People have to approach me 3

By joining clubs/societies 2

Go to clubs or day centres 2

Difficulties

Negative reactions (stigma) from the general population 3

General community scared of mental illness 2

*"The trouble is is that most people don't have a clue about how to deal with mental illness. Most people shy away from it. There is this lady for example who sometimes picks me up to take me to bridge. I once asked her to pick me up from the day-centre but she didn't feel comfortable doing it at first. In the end she decided that she might be all right if she was with me. Still she wouldn't even come into the garden. It was as if she was scared of us, as if we were unusual or abnormal. It made me feel pretty dreadful. I suppose she just doesn't understand. Mind you even staff can be funny sometimes. We were recently told that we couldn't sit on the steps outside. Why? Well just in case members of the public are intimidated when they walk through. I think that's dreadful don't you".*

General community hostile to people with mental illness 1

*"They think we are nasty but actually we are reasonable, nice people. I avoid people like that if I can".*

Not trusting other people with mental health problems 3

*"People you mix with in my world are more acquaintances. You wouldn't trust them. They are as untrustworthy as I am".*

Very difficult now 1

Would rather avoid people 3

You have no privacy/too many people around 1

Feels safer to avoid people - avoid getting rejected or taken advantage of 2

Lack of trust in people 3

Giving vibes for people to stay away because of a fear of being rejected 1

*"I think its because I'm too afraid of being rejected".*

People have to prove they are trustworthy 1

### **3. The interpersonal problems reported**

Others take advantage 4

One-sided friendships 1

People take advantage of me 3

Often feel neglected by friends 1

Don't believe people are trustworthy 6

Must choose friends with care 3

Don't trust people 4

*"You just have to be really careful who you associate with. People just cannot be trusted you see; they are bound to let you down".*

Feels as if people pretend to care about me but don't mean it 1

Need to protect oneself 5

Need to maintain distance from people as a protection against being hurt or rejected 5

*"I'm going to have to back off. I think we would get too close otherwise. If I let anyone near me they will hurt me. I need my shell around me. God, it sometimes feels as if I am locked up - it can feel really unbearable. But if people find out what I'm really like them they might not like it".*

I give off vibes for people to stay away 1

*"I don't mean to give off those vibes. I suppose its a sort of force-field to stop being hurt and rejected".*

Unable to form relationships with people 4

Unable/unwilling to form loving relationships 2

Difficulties with intimate relationships 2

Preference is to be alone 2

Overly critical of people 1

Too critical of people, I expect too much 1

Negative reactions from others 2

Outside people do not want to know people with mental health problems 1

I am a soft target for people to have a go at 1

Negative effects of symptoms 1

Inability to do the things needed to maintain friendships (e.g. writing letters) due to feeling so low and apathetic 1

Not fitting into society 1

Never managed to share interests with people 1

*"I've never matched up with people - I'm not a sportsman or an artist".*

Helplessness 1

Troubles just stick to me 1

*"You see troubles always follow me. No matter what I do things always go wrong. No, I've no idea at all why this is the case. Born like it I suppose. Bloody hell, when I die people will probably drop my body bag while they are carrying it."*

Low self esteem 1

Don't understand why people would want to know me 1

*"I'm ugly and my personality, well, there's nothing much there is there".*

A dislike of social rules

Don't like social rules 1

*"People make agreements and you have to abide by them - I can't really be doing with that".*

**4. Participants' explanations for their interpersonal problems**

No interpersonal problems reported 1

Others fail me or are untrustworthy 2

Other people's failures/dishonesty 2

Lack of assertiveness 3

*"I suppose if I was more assertive I would be scared at people's reactions. Some friends like —, well they can have a real temper. If I stood up to her then I'm not sure what reaction I'd get. I'm worried I'd get hurt, scared I suppose. If I rang up a friend and asked for something important then I suppose I would be scared they would put the phone down".*

Lack of social skills

Don't know how to go about making friends 1

Negative experiences of early relationships (3)

Lack of emotional contact early on, therefore learned to cope on my own 1

So many deaths experienced no longer want to get close 1

Difficult early relationship with father 1

Negative effects of symptoms

Shame about depression and failure in life makes me want to hide 1

Low self esteem 1

**5. Participants' early experiences with family and friends**

***a) Family***

Positive comments 2

Good 1

Generally OK 1

Negative comments 6

Felt alone in the family 3

Little emotional contact 5

Little emotional contact with parents 5

*"I think I crave affection because I never got it off my mum. I can still feel like a vulnerable child. Dad could be nice when he was around".*

Negative emotional contact 1

Mother continually criticised the participant 1

*"Mum could be really nasty to me - she was never like that with — (brother). She would say really hurtful things like I'm fat. Yea, looking back I can remember lots of times when she really hurt my feelings. She could be so cruel. That hasn't healed. You can't heal things like that in the way a bruise or broken arm can heal. She was just a source of continual criticism".*

Anger expressed about early upbringing 3

Lack of personal control 5

Father extremely abusive towards mother 1

Father made it difficult to form own identity 1

Father cold and domineering 1

Always questioned why original parents did not keep me 1

Strict upbringing 2

*"It was difficult. I think I was a tomboy really but I was never allowed to do those sorts of things. My parents would always say 'young ladies don't do things like that'".*

Mother extremely possessive 1

*"I really wanted to be a nurse but I would have had to go to London and my mother did not want me to leave home. She was very possessive you see. So I had to continue working in — which was awful. In the end I went to Australia to get away from her".*

**b) School**

Generally positive 3

Good 1

Had several friends 1

Some of the children were nice sometimes 1

But a very difficult time initially when I moved from Scotland to England 1

Mixed 2

Often felt alone but enjoyed the work 1

Generally negative 3

Lonely at school 2

Didn't make any friends 1

Very lonely time 2

Teased 1

**6. How the onset of the participants emotional difficulties impacted on their relationships**

Isolation 6

Lonely and unhappy even as a child 5

Became isolated from people 4

*"I do not want them to see me like this".*

Personal shame 3

Everyone knew I was ill and that was terrible 1

Often try to cover it up to people 2

Resentment experienced from others 1

Children resented me becoming ill/didn't understand why I was ill 1

Resentment expressed at others 1

Deep anger expressed at family 'turning against' participant 1

Lost assertiveness 1

Lost ability to be assertive 1

## **7. Describing Current Relationships in the Family**

Feel Shameful 2

Feel brought shame on the family, guilt 1

Feel a complete failure with the family 1

*"When I came out and then later told my them I was an alcoholic, I think my parents felt it was a big slur on the family. I just feel a complete failure".*

Not understood by the family 3

Don't understand me 1

Some members of the family can't relate to my illness and ignore me now 1

Family feel I should just be able to cope and get on with things 1

No present contact with family 2

Participant not in contact with ant members of his family 2

*"I haven't been sociable with them for years. Yes, well that's the way it goes isn't it"*

*"No none now, none at all".*

Difficult to maintain contact 1

Find it difficult to do the things that maintain relationships 1

## **8. The Family (closest member)**

Cousin 1

Dad 1

Mum (daughter closest but not seen) 1

Nephew 1

Brother 1

Son 1

None 2

### ***a) Level of contact***

No contact 2

No contact at the moment 1

Once every 6 months 3

Once every 3 months 1

Every day 1

***b) Activities***

None 3

None 2

None at the moment 1

Talking 4

Talking 4

Support me on the phone 1

***c) Feelings associated with being with the person***

General positive comments 4

Don't want to lose touch with them 1

Fine/good 2

Great fun sometimes, a pain at others 1

We chat a lot and that 1

No contact wanted 1

*"I don't want to see him, dad would probably just have a moan".*

Positive emotions expressed towards person 4

I love him/her dearly 1

Feel very close sometimes 1

He genuinely cares about me 1

Can listen to me 1

***d) What is gained from the relationship/type of support received***

Nothing 1

No emotional support 1

They don't drag up the past 1

Emotional support 5

Empathy and understanding between us 1

Tries to understand me 1

Emotional support 4

Can relate to me 1

Talk about our difficulties 1

Always there 1

*"He's always there and that's nice. He can make me feel like a little child - all safe so that nothing can hurt me".*

Non-emotional support 2

Financial support 1

A contact in the participant's home town 1



**e) What are the negative aspects of the relationship**

None 1

None (but distant family) 1

Don't receive enough support 4

Gets prickly if I lean on him too much 1

Doesn't understand what I'm going through 1

Only see him once or twice a year 1

Can't really tell him/her how I feel 1

*"I wouldn't like him to see too much of my depression, or how much I am suffering, or when I feel suicidal. I don't want him to know; he couldn't do anything. Yes, I do feel I have to protect my children from the truth".*

Only support is financial 1

*"I feel really that I'm out in the big, wide world on my own. There isn't any other way that he could really support me".*

Loss of self esteem 3

Feel intimidated by him 1

*"We were always compared by dad. I used to be his favourite, but it is as if he deliberately overcompensates for that now".*

Feel patronised by him 1

*"As if he has finally beaten me, which in a sense he has. He has a family, a car, he has sort of won. He's got the things that make people happy. I'm alone, on benefits and have no life. I've failed despite being the bright one".*

Would just have a moan 1

Other

Will not stand up to my father 1

**f) Circumstances in which support is accessed**

Support not accessed 2

Practical support accessed 1

Can't really tell him/her how I feel 1

Occasionally on the phone 1

When he visits me 1

**g) The discrepancy between actual and ideal levels of support**

Would like more 5

Lack of contact explained as being due to external, non-emotional factors 2

Trouble is that they are too busy bringing up their children 1

But he has a business and a rough marriage 1

'Fault' with the family member 2

Yes, and I tell him so 1

Enormous anger that no more is received 1

'Fault' with the participant 1

Participant blames himself for failing to maintain contact 1

### Contact appropriate 2

*"Yes it is about the right amount of contact at the moment. Sometimes though I do wish dad could give me a huge hug and take all the pain away".*

## **9. Describing Current Relationships with Friends**

### No friends reported 3

*"I used to go to the day centre but I used to mind my own business when I was there".*

### Not feeling worthy of friends 1

*"People at AA tell me they are my friends but I don't really believe them. There's no reason why they would want to be is there".*

### Avoidance of people with mental health problems 1

People at day centre talk about their troubles too much 1

### Lost contact since emotional difficulties began 2

Feel out of touch with most friends, they have careers and fellas 1

Lost contact with people outside mental health services 1

### Positive experiences with friends 2

A range of friends maintained 1

Friends instrumental to happiness 1

### Difficulty maintaining relationships 1

Find it difficult to do the things needed to maintain relationships 1

*"I find it difficult to write to people. When I get low I can't do as much. Also, when I think of writing a letter I find it difficult. I don't feel I have much to say. What's the point, everything I write is going to be crap".*

### Other

Incestuous nature of main social club 1

Hate it when gossip flies about 1

## **10. Friends (closest member)**

### No friendships reported 3

Long term friend formed outside mental health services 2

More recent friendship formed outside mental health services 1

Sexual partner formed within mental health services 1

Friendship formed within mental health services 1

### ***a) Level of contact***

### No friends reported 3

Once every two or three weeks 3

Once a week 1

Every weekend and on the telephone during the week 1

***b) Activities***

Social activities 4

Go to lunch 1

Have a coffee 1

Spend all day together 2

Go for walks 1

Go for drinks 1

Do hobbies together 1

Support 1

Give each other support 1

***c) Feelings associated with being with the person***

Feeling inferior to the person 1

General positive comments 4

Good company 3

Does not talk at me like most people here 1

Nice to talk to someone who knows you 1

Emotional support 2

***d) What is gained from the relationship/type of support received***

Emotional support 5

Talk to him/her if I am upset 1

Would stand up for me in my absence 1

Comfort 1

Support each other 1

Be with someone and it is OK, even if you are down 1

Share thoughts with 2

*"It is a rare commodity for someone with mental health problems to have someone who will just listen and be interested; a rare commodity".*

Having a laugh 1

***e) What are the negative aspects of the relationship***

Friend being dominant/loss self esteem 2

Friend is dominant 1

Friend cannot be challenged because of her temper 1

Friend makes participant feel stupid 1

Friend sometimes ignores participant 1

Friend's mental health problems 2

Gets funny like me 1

Encourage each other in self-destructive behaviours 1

One sided relationships 2

Afraid of asking for too much 2

Must not lean on them too much 2

Nothing 1

Other

Person sometimes clings to me 1

*f) Circumstances in which support is accessed*

When meeting e.g. for lunch 3

Difficult to ask for support when needed 2

*g) The discrepancy between actual and ideal levels of support*

No friendships 3

Would like more support 3

Practical/non-emotional reasons for the discrepancy

Lack of contact explained then challenged 1

*"she's married to a solicitor and she has to keep the marriage going and things like that. She also has her bridge to play".*

*"Not as often, but you have to be realistic. She's got responsibilities and elderly parents. You can't take over someone's life".*

Can't lean on them too much 2

Mixed 2

*"Sometimes it feels as if I would like to see her more. Sometimes I feel I would like to be alone".*

**11. Describing Current Relationships with Professionals**

Generally negative 5

Not enough support 3

Don't get enough support 1

*"You know when I came out of hospital last year I had no support. Isn't that bad".*

Staff not interested in patients 3

Most staff couldn't care less about you 1

*"If you see a psychiatrist say then all you get at the end is 'see you in three weeks time and I hope you do OK'. They couldn't care less really and they then just bring the next one in".*

Staff do not want to listen 1

*"Staff here don't want to listen. If I want to get on then people should listen to your troubles. I don't want a conversation I just want people to listen. You can say so much when you talk and get things off your chest. I don't bother trying anymore. As long as they don't try to tell me what to do anymore".*

Staff need more training 1

Need people who are more qualified 1

Not close to staff 4

Not interested in staff/not close to any of them 2

*"sometimes you forget who the staff are - you can't recognise them sometimes".*

Don't understand what professionals are trying to achieve 1

You can't build a 1:1 relationship with them 1

I wouldn't confide in any of them 1

*"If I felt down I wouldn't go to them. I would just close the door".*

I feel on a different wavelength from them 1

Support difficult to access 2

I'm not used to asking for help 1

Don't feel I'm worth someone else's attention 1

Staff do not approach you, not easy to approach them yourself 1

Smothering 1

Mental health services have sort of smothered me and taken away my ability to get on with a normal life 1

*"It's safe but it also holds, contains and traps. It has limited expectations of you. It is too gentle, it doesn't push you".*

Generally positive 3

Named professional the only person the participant feels he/she can really trust 1

*"B (her psychologist) is the only person I can really trust. Maybe she is out for my interests - I don't really think anyone else is. Maybe she sees someone in me, something that is worthwhile. I feel close to her and trust her. Because I don't trust people I don't let them near me. I've let B in where I've not let people in before".*

Lots of people who are very supportive 1

12. Professionals (closest member)

**a) Level of contact**

Once a week 2

When needed 2

No close professional 4

**b) Activities**

Emotional support

Talk about difficulties 3

Therapy 1

**c) Feelings associated with being with the person**

Safe and comfortable 3

We are like sisters 1

**d) What is gained from the relationship/type of support received**

Emotional support 4

*"Like a conductor who by knowing the music can bring it out properly".*

Only person who understands me 2

Fun 1

Non-emotional support 1

Other

Like a best friend 1

**e) What are the negative aspects of the relationship**

No professional close (see general section for negative aspects) 4

Nothing 1

Not enough contact 3

Now see professional in group format 1

Not always available 1

Don't want to ask too much of him 1

Other

Too many silences allowed in therapy 1

Not strict enough with me 1

**f) The discrepancy between actual and ideal levels of support**

No close contact reported 4

None 2

Would like more 2

Would like to see professional in 1:1 therapy 1

*"I only see her in a group now. I don't like the group. When I was in 1:1 I started to open up with her. I could be completely honest - I can't do that in the group. They don't understand me like B does. She knows what I'm about. I'd give my right arm to be back in 1:1. I don't know where to put my feelings now".*

Would like more but person is very busy 1

**13. Participants' views about the cause of their emotional difficulties or symptoms**

Biological with the influence of simultaneous life events not acknowledged 1

Disease which began about the same time as losing job/car crash 1

Biological plus life events 1

(life events included below)

Life events 6

a) non-personal

Work stress 1

Becoming burnt out at work 1

### Excessive drug use 1

#### b) Personal

##### Helplessness 2

Wife and family leaving home (deep anger and sense of injustice and helplessness expressed) 1

Dad's abuse of mother and helplessness at being unable to do anything about it 1

##### Lack of personal control 2

Dominant father figure, couldn't find my own identity 1

Strict upbringing 1

*"It's like all that is coming out now".*

##### Bereavement 2

A series of close friends or partners dying 1

Stepmother dying of cancer 1

Nursing father with cancer 1

##### Emotional neglect in early life 5

Mother leaving early in childhood 1

*"Dad deleted everything of her you see".*

Emotional neglect in early life 5

##### Violent attack 2

Rape/attack leading to deep mistrust of people 2

*"You see the man who tried to kill me was the man I left my husband for. I had to go into refuge for two years".*

*"Life became pointless afterwards". 2*

##### Loneliness 2

Being in refuge 1

Never formed any lasting friendships 1

*"even as a child I was a real loner - I never made any friends".*

### **14. Participant views about whether relationship difficulties contributed to their emotional difficulties or symptoms**

#### No impact

No, its a disease 1

#### Negative experiences in the family 6

##### Lack of personal control 2

Mother's possessiveness 1

*"Oh I suppose it did a bit, at least at first. You see I first became really depressed in Australia. You see I had never learnt to stand on my own; my mother had done everything for me. I'd never washed my own hair or done washing and things like that. I got in a state I suppose because I couldn't cope. It was a combination of home-sickness and not being able to cope I suppose. They wouldn't let me into hospital in Australia though and the drugs they gave me just made me worse. So I had to come home".*

Father's abuse of mother 1

Father's domineering attitude - difficult to form own identity - low self esteem 1

##### Emotional neglect 3

No early emotional contact 2

Being treated negatively by family at the moment 1

Never received praise or affection, therefore felt ugly and useless since 1

*"I'm just not worthy of having good friends".*

Loneliness 1

Betrayal (perceived) by family resulting in loneliness 1

Negative reactions from others 1

Shame of other's reactions 1

*"It was terrible coming home. People in — saw me in a terrible state. Gosh I suppose I've got really bad memories of that time. You see everyone knew I was ill and that made me feel useless and really bad. Only one person wanted to know me at that point. We are still friends although I suppose we have a bit of a love/hate relationship".*

Bereavement 2

Death of mother 1

Stepmother's death 1

Other

Murderous attack by boyfriend leading to refuge and isolation 1

Relationships main thing that have helped me to cope 1

**15. Participant views about whether their emotional problems or symptoms had changed their relationships with other people**

Never had any 'real' relationships 2

Generally negative 6

Negative reactions of others 3

People are suspicious because I go to mental health services 1

Negative effects of labels and being in contact with mental health services 2

*"People develop the idea that I'm a nut case, therefore it's not worth bothering to get to know me. Who would want a friendship with a nutter, what with that kind of label. As soon as I say I go to mental health services people then people want to keep me at arms length. Yet I can't lie, it's part of my identity, and anyway I'd soon be found out. I suppose they feel they have enough troubles".*

General population not understanding of difficulties 1

Results in social withdrawal 3

Means I withdraw from people 1

Ashamed by how I am, want to withdraw 1

*"I just don't tell them what I'm up to or that I go here. I'm embarrassed I suppose".*

Drift into own world now 1

Negative effects of symptoms 4

Lose concentration when depressed and then can't talk to people 1

Depression got the participant isolated 1

*"What can you do when you've got nothing - nothing".*

Depression makes me see the wrong in people 1

Being too negative drives people away 1

Feel stupid 2

Makes me feel stupid so I sometimes avoid people 2

Stuck in mental health services 1

Being stuck in a mental health services 1

*"It's like a ghetto, you are safe in it but you can't break out of it. Almost everyone I know now is in them".*

Others



Low self esteem 1

*"Well I'm fat, ugly, depressed and a drunk. Would you want to be friends with someone like that?"*

Anger leaves me with a very aggressive voice 1

If I get aggressive people will not put up with it 1

Snap sometimes with the frustration 1

## **16. Participants' views about how they would like their social relationships to be different**

No changes desired 1

Don't want relationships at the present time 1

Form closer relationships 3

Have people who are closer to me 1

Have someone who loves and understands me 1

Companionship 1

Someone to talk to 1

Obtain a sexual partner 2

Get married 1

Have a job/goals 2

Have a job 1

Have a focus in life 1

Do something creative that would give personal satisfaction 1

Be more assertive 2

No longer experience symptoms 1

To become less depressed 1

Change early family relationships 2

Father would have been sober 1

Parents would have taken an interest in me 1

Specific changes in relating to people 3

Greater trust in people 1

Like to trust people more 1

Not feel I am letting people down 1

Keep temper under control 1

Eliminate shame 1

Move 1

Go to a different area of the country and re-invent myself 1

No more abuse from strangers 1

*"They should learn that we are nice like everyone else or they should leave us alone".*

## 17. Desired changes in service provision

General satisfaction expressed 1

General disillusionment 3

Better to sort things yourself 2

Scepticism expressed at the ability of mental health services to do anything 1

More contact/support wanted from staff 5

More 'personal' contact with psychiatrist 1

See someone who is more qualified 1

Staff should spend more time with the patients 3

*"It could be different here if the keyworkers had regular chats with you, even if only once a month, instead of you waiting to see them. Nine times out of ten when you are in a crisis then they are not there".*

An opportunity for people to form 1:1 relationships with staff 2

*"It's about forming a good relationship with just one mental health professional. Who takes an interest and who is a real person to me".*

Form real relationships with staff 2

*"Mental health services can feel like a mirage, the relationships often do not seem to be real. It's a false atmosphere, staff relate because it is their job not because they are interested in me. Because of that it is often difficult to tell how you are really getting on. There is no wall to check your value against".*

More contact with specific professionals

A CPN 1

Improved service organisation 5

Services too disorganised 1

Staff need to take a more constructive approach with patients 3

*"I think people are just left to drift for too long. They are basically herded like cattle. You must keep on at people and not allow them to drift away. Things must be started for them and followed through. If there is no foundations, well it's like a wall without a foundation. It will just break down." "People are only brain dead because they vegetate. It does their brain in".*

Much more co-ordinated support to make me less reliant on mental health services 1

*"Some people are very happy not to leave mental health services. I'm not but there is no recognition that that is the case. I can't do it all on my own. Staff need to communicate much better with each other and plan a co-ordinated approach to someone's life".*

Break out of mental health cycle - MH services - label and identity - limited circle of friends and contacts - more reliant on mental health services and so on 1

Too late for services to change my life much 1

Activities 1

Someone to take me out every now and again 1

Social skills training 1

Training on social skills and relationships 1

*"I wish someone would give me help with relationships. To show me how to make friends or to give me guidelines and boundaries ... to explain how things work and to tell me what to say".*

## **APPENDIX 12**

### **The Inter-Rater Reliability Study**

## **INTER-RATER RELIABILITY STUDY**

### **INSTRUCTIONS FOR RATERS**

1. The aim of this study is to determine to what extent an independent rater concurs with the codes and categories I have generated from the responses given by participants to the research questions. I have provided you with four interviews chosen at random from each of the two groups of participants I interviewed (so that there are two in each group). I have also enclosed two rating scales (with four copies of each).
2. To begin with I would like you to use the 'category' rating scale. I would like you to read through each interview carefully. As you do so I would like you to think about two research questions. First, what explanations do the participants give for the interpersonal problems (not symptoms) they experience? Second, what sorts of relationship difficulties appear to have contributed to the participants' emotional difficulties or symptoms?
3. Having read each interview I would like you to take one of the interviews and one of the 'category' rating scales. Put the participant's number at the top of the rating sheet. I would like you to read the interview again, this time ticking one or more of the category boxes whenever you feel a participant has made a comment that fits it. Each box can only be ticked once for each person no matter how many times they mention that issue.
4. Could you please complete this procedure for each interview that I have given you, taking a new rating scale for each one.
5. Could you then take the 'codes' rating scale. Again I would like you to repeat the procedure, this time ticking off the boxes on the 'coding' scale. As you will see these boxes contain more specific comments or descriptions. Some comments will not fit any of the codes mentioned in the boxes. Could you ignore these comments unless you feel they are particularly relevant to the two research questions specified above. If you do feel it is relevant would you give a brief summary of its content on the bottom of the rating scale.

***Thank you for your help***

## **CODING RATING SCALE**

*Participant number:-*

### **Question 1:- What are the participants' explanations for their interpersonal problems**

- |   |     |
|---|-----|
| No interpersonal problems reported                                      | [ ] |
| No longer know how to socialise   | [ ] |
| Don't know what to say to people  | [ ] |
| Don't understand the opposite sex                                       | [ ] |
| Do not have the social skills/education to mix with people              | [ ] |
| Don't know how to go about making friends                               | [ ] |
| Lack of emotional contact early on therefore I learnt to cope on my own | [ ] |
| So many deaths experienced I no longer want to get close                | [ ] |
| Difficult early relationship with father                                | [ ] |
| Shame about depression and failure in life makes me want to hide        | [ ] |
| Low self esteem   | [ ] |
| A lack of assertiveness   | [ ] |
| Find it difficult to meet people's needs                                | [ ] |
| No opportunity to meet people in general                                | [ ] |
| No opportunity to meet people outside mental health services            | [ ] |
| Voices confuse and undermine me   | [ ] |
| It's a result of mental health problems                                 | [ ] |
| Trust in people has gone  | [ ] |

- |   |     |
|---|-----|
| Stigma and negative reaction from people outside mental health services | [ ] |
| A bad physical appearance   | [ ] |
| Other people's failures or dishonesty                                   | [ ] |

**Question 2:- What sorts of relationship difficulties have contributed to the participants' emotional difficulties or symptoms?**

- |  |     |
|--|-----|
| No impact  | [ ] |
| No direct cause, yet acknowledgement that relationships can make the person feel worse | [ ] |
| Always found it difficult to make friends  | [ ] |
| No relationships with, or difficulties forming relationships with, sexual partners     | [ ] |
| Mother's possessiveness  | [ ] |
| Father's abuse of mother   | [ ] |
| Father's domineering attitude » difficult to form identity » low self esteem           | [ ] |
| No early emotional contact   | [ ] |
| Being treated negatively by the family at the moment                                   | [ ] |
| Never received praise or affection, therefore felt ugly and useless since              | [ ] |
| Betrayal by family resulted in loneliness  | [ ] |
| Personal shame increased by others' negative reactions                                 | [ ] |
| Because very sensitive/shy   | [ ] |
| Extreme loneliness and isolation therefore got lost in a dream                         | [ ] |
| Being with too many people brings on symptoms  | [ ] |

Other's problems contributes to participant's own symptoms [ ]

Death of mother [ ]

Stepmother's death [ ]

Murderous attack by boyfriend leading to refuge and isolation [ ]

Family murder the cause [ ]

Because intimidated by others [ ]

## CATEGORY RATING SCALE

*Participant number:-*

### Question 1:- What are the participants' explanations for their interpersonal problems

No interpersonal problems reported [ ]

Others fail me or are untrustworthy [ ]

Lack of social skills [ ]  
*e.g. inability to strike up a conversation or converse (lack of assertiveness should be included in the next category)*

Lack of assertiveness [ ]  
*e.g. unable to tell people what they want from relationships*

Find it difficult to meet people's needs [ ]  
*e.g. do not know what to say to comfort people*

No opportunity to meet people [ ]

Negative effects of symptoms [ ]  
*e.g. voices that stop people interacting, or feeling too low to socialise*

Negative experiences of early relationships [ ]  
*e.g. no affection from family therefore it is difficult to receive affection now*

Low self esteem [ ]  
*e.g. I'm too ugly for people to be interested in me*

Stigma and negative reactions from people outside [ ]  
*e.g. once people know I am mentally ill they no longer want to know me*



**Question 2:- What sorts of relationship difficulties have contributed to the participants' emotional difficulties or symptoms?**

Relationship difficulties were in no way responsible for symptoms [ ]

Never had any 'real' relationships [ ]

Because it was difficult to form relationships  
*e.g. I just didn't know how to get a girlfriend* [ ]

Because I was so lonely [ ]

Too much contact with people brings on symptoms [ ]

Listening to others' problems causes symptoms [ ]

A lack of personal control in early family life  
*e.g. a very possessive mother, father's domineering attitude* [ ]

Emotional neglect in early family life  
*e.g. I never received any praise or affection* [ ]

Someone died [ ]

Negative reactions from others towards people with mental health problems [ ]

### **APPENDIX 13**

#### **The Questionnaires Developed for the Respondent Validity Study**

## **RESPONDENT VALIDITY STUDY**

### **Depression**

#### **1. Introduction**

Thank you again for giving me your views in this research and for agreeing to comment on the results of the study. I have formed various ideas and I would like to know if these make any sense to you. The thoughts I want to talk to you about are only my views. They may not feel right to you or you may think I have only got some things right. I would be very grateful if you could tell me what you think. It will help me to confirm some ideas and change others.

#### **2. The results of the study**

##### ***a) What friends are for***

People said they thought friends were for various things. Do you agree with these or do you think some of these are wrong? Are friends for anything else?

*Explore participant's thoughts about whether friends are for companionship, talking and sharing thoughts, emotional support, practical support and having fun with.*

##### ***b) Ways of making friends***

People talked about many different ways of making friends. Do you do any of these things? Is there anything else that you do? A lot of people with depression said that they no longer really bothered to make friends or that people had to come to them. Is this true for you?

*Explore also the difficulties reported in making friends (negative reactions from the general population, not trusting people with mental health problems, lack of trust in people in general, and would rather avoid people).*

##### ***c) Interpersonal problems reported***

People suffering from depression have talked about the types of difficulties they have in relating to other people. Do these make sense to you? Are these difficulties ones that you also experience?

*Explore the interpersonal problems reported (unable to form relationships with people, negative reactions from others, others take advantage, need to protect oneself, negative effects of symptoms, not fitting into society, preference is to be alone).*

##### ***d) Explanations for the interpersonal problems***

People suffering from depression gave several reasons why they sometimes had difficulties relating to people. Do these make sense to you? Do these things sometimes make it difficult for you?

*Explore the range of explanations given (others fail me or are untrustworthy, negative experiences of early relationships, lack of assertiveness).*

***e) The impact of relationship difficulties on a participants' emotional difficulties or symptoms***

Many people with depression said that relationship problems had either caused the depression or made it worse. Is this true for you?

*Explore potential impact of negative experiences in the family including lack of personal control, emotional neglect and loneliness, negative reactions from others, bereavement).*

***f) The impact of a participants' emotional difficulties on his/her relationships***

Many people with depression said that their symptoms have a negative impact on their relationships with people. Does this happen to you?

*Explore negative effects of symptoms, negative reactions from others, feelings of stupidity and social withdrawal).*

One person said that they felt stuck in mental health services. Do you sometimes feel like this?

***g) Desired service changes***

Only a few people with depression seemed completely satisfied with what they got from services and professionals. Many thought things could be better. Do you agree with these things? Is there anything you would add?

*Explore desires for an improved service organisation, closer contact and more support from staff.*

**3. Exploring the themes developed**

***a) Loneliness and isolation***

Many people said that they felt fairly alone in life. Is this true for you? Are there any particular reasons why you feel lonely?

***b) The negative reactions (stigma) from others***

Some people felt that the general population was prejudiced against people with mental health problems. They said that people can have unreasonable and negative reactions against people who are having treatment in mental health. Some thought that they did not fit into society. Do you feel this? Some people thought general society rejected them. Do you think this is so?

Do you sometimes feel angry at this? Does it make you feel bad inside?

*Explore the effects of stigma on the participants.*

***c) Home and school***

Many people with depression felt that their early life with their family had been difficult. Some said that they had felt lonely and isolated in their family when a child and that they seemed to receive little praise or affection. Is this true for you? For some school was a better experience. Did you get bullied or teased? If so do you think you know why you got teased?

***d) An emotional versus a practical focus towards relationships, a desire for intimacy and relationship needs***

Many people with depression felt that they did not get enough emotional support from their relationships. In fact many wished for closer more intimate relationships with people. Is this true for you? What makes it difficult to get close to others? Do you sometimes fear that people will take advantage of you or that you have to be careful who you trust? Do you sometimes feel you have to protect yourself from being hurt and rejected? Is it difficult to be assertive with people? If so, why is this difficult? Some people complained that it was difficult to form real or intimate relationships with staff. Do you think this is true for you?

**4. Exploring the developed theory**

***a) Inability to reflect on one's own mental states and the mental states of others***

I wonder if you find it difficult to know what other people are thinking?

Does it surprise you sometimes that people do things and it is difficult to work out why they are doing it?

What do people think of you?

Is it sometimes difficult to work out how you are feeling?

***b) Social comparison***

People suffering from depression often seemed to compare themselves with people who were doing well in life and, as a result, often reported feeling generally inferior to people. Do you think this is what you do? Do you sometimes feel you have to put more effort into relationships than the other person. If so, why? What do you think of the other people you know who are currently receiving support for emotional difficulties?

***c) Attachment models***

Some people suffering from depression said that their early relationships with their family, or other early experiences, now made it difficult for them to trust people enough to get close to them. Do you feel this? Do you feel that you find it difficult to trust people?

*Explore further how their early relationships have impacted on their current views about relationships.*

## **RESPONDENT VALIDITY STUDY**

### **Schizophrenia**

#### **1. Introduction**

Thank you again for giving me your views in this research and for agreeing to comment on the results of the study. I have formed various ideas and I would like to know if these make any sense to you. The thoughts I want to talk to you about are only my views. They may not feel right to you or you may think I have only got some things right. I would be very grateful if you could tell me what you think. It will help me to confirm some ideas and change others.

#### **2. The results of the study**

##### ***a) What friends are for***

People said they thought friends were for various things. Do you agree with these or do you think some of these are wrong? Are friends for anything else?

*Explore participant's thoughts about whether friends are for companionship, talking and sharing thoughts, emotional support, practical support and having fun with.*

##### ***b) Ways of making friends***

People talked about many different ways of making friends. Do you do any of these things? Is there anything else that you do?

*Explore the various ways participants went about making friends (no difficulties reported, no active efforts made, through conversation, by joining clubs and societies). Explore also the difficulties reported in making friends (negative reactions from the general population, too many needs or emotions expressed by people with mental health problems, fear of people in the general community).*

##### ***c) Interpersonal problems reported***

People suffering from schizophrenia have talked about the types of difficulties they have in relating to other people. Do these make sense to you? Are these difficulties ones that you also experience?

*Explore the interpersonal problems reported (none, unable to form relationships with people, negative reactions from others, people get too close, negative effects of symptoms, dislike contact with people expressing negative emotion)*

##### ***d) Explanations for the interpersonal problems***

People suffering from schizophrenia gave several reasons why they sometimes had difficulties relating to people. Do these make sense to you? Do these things sometimes make it difficult for you?

*Explore the range of explanations given (no problems reported, lack of social skills, difficult to meet people's needs, no opportunity to meet people, negative effects of symptoms).*

***e) The impact of relationship difficulties on a participants' emotional difficulties or symptoms***

Many people with schizophrenia didn't think that relationship problems had caused their symptoms or made them symptoms worse. Is this true for you? Those that did talked about how work stress and being lonely (expand) had made things worse. Did any difficulties in relationships make your difficulties (detail) worse?

***f) The impact of a participants' emotional difficulties on his/her relationships***

Some people with schizophrenia said that their symptoms had a negative impact on their relationships with people. Did this happen to you?

*Explore negative effects of symptoms, negative reactions from others and forced separation from others.*

Some people said that they got to know more people after they became ill. They met more people in services. Did this happen to you?

***g) Desired service changes***

Some people were happy with the treatment and service they received. Others thought things could be better. Do you agree with these things? Is there anything you would add?

*Explore the fact that many of this group were satisfied. Where they were not they wanted more contact from staff, more activities and changes in staff attitudes.*

**3. Exploring the themes developed**

***a) Loneliness and isolation***

Many people said that they felt fairly alone in life. Is this true for you? Are there any particular reasons why you feel lonely?

***b) The negative reactions (stigma) from others***

Some people felt that the general population was prejudiced against people with mental health problems. They said that people can have unreasonable and negative reactions against people who are having treatment in mental health. Some thought that they did not fit into society. Do you feel this? Some people thought general society rejected them. Do you think this is so?

Do you sometimes feel angry at this? Does it make you feel bad inside?

*Explore the effects of stigma on the participants.*

***c) Home and school***

Many people with schizophrenia said that they had a good life when being brought up in the family but that they hated school. Did this happen to you? Was school much worse than being at home? If so why was school much worse? Was it because it was difficult to get on with people? Did you get bullied or teased? If so do you think you know why you got teased?

***d) An emotional versus a practical focus towards relationships and relationship needs***

Sometimes people with schizophrenia thought that it would be easier to get on with people if they had better social skills (expand). Is that true for you? They also said they would like more relationships with people? Would you?

They didn't often say they wanted closer relationships with people. In fact when people got too emotional it sometimes annoyed them. Is that true for you?

#### **4. Exploring the developed theory**

##### ***a) Inability to reflect on one's own mental states and the mental states of others***

I wonder if you find it difficult to know what other people are thinking?

Does it surprise you sometimes that people do things and it is difficult to work out why they are doing it?

What do people think of you?

Is it sometimes difficult to work out how you are feeling?

##### ***b) Social comparison***

People suffering from schizophrenia generally had several friends who also had treatment in mental health services. Do you? They also felt fairly equal to people (expand and bring in idea of who they compare themselves to). Do you think this is what you do?

##### ***c) Home and school***

Was it difficult at school to work out how to play with people?

Did you know what children at school thought about you?



## **APPENDIX 14**

### **A Brief Summary of the Findings from the Respondent Validity Study**

## **A BRIEF SUMMARY OF THE FINDINGS FROM THE RESPONDENT VALIDITY STUDY**

### **The D group**

Both participants agreed with almost all the codes and categories generated from the D group's original responses to the research questions. Their comments served to enrich the themes and theory developed in this research rather than suggest a need for major modifications or changes.

#### ***(i) Comments on the codes and categories generated in the research***

Both of the participants in this group thought that the codes and categories generated in the research provided an accurate description of their own experiences. They talked about their fears of being hurt or rejected and the difficulties they experienced in trusting people enough to form the intimate relationships they desired. One of the participants became tearful during the discussion when she talked about the loneliness and lack of emotional affection she had experienced in childhood.

**"Yes, that's really true for me. I think it made me really unconfident even as a child. I suppose it feels difficult to accept that people can really love me"**

Both participants found it difficult to be assertive with people and both agreed that the stigma associated with mental health problems further exacerbated their relationship difficulties. Both thought services should be better organised and both expressed a desire for more intimate contact with staff.

#### ***(ii) Comments on the themes generated in the research***

Again, both participants agreed with and confirmed the themes that were generated in the course of the research. Both reported feeling very alone in life.

**"I can feel so alone sometimes that it actually gives me a physical pain here in the heart".**

One person agreed that he had better memories of school than he had of early family life. The other thought both had been very unhappy periods. Both agreed (in fact a

great deal of emotion was expressed) that they desired, perhaps more than anything else, closer and more intimate contact with other people. Yet they also agreed that they remained extremely afraid that such contact might be betrayed or their efforts rejected.

**"Its like, well if she rejected me it would be the last straw. I'd have nothing left".**

***(iii) An exploration of the emerging analysis***

Both participants sometimes found it difficult to work out how they were thinking or feeling particularly when they were very low and life felt pretty hopeless. However, both reported being able to work out what others were thinking or feeling although one thought she usually saw only the negative things in people. She also thought she probably interpreted what people said in a very negative way.

**"I think it's that I'm oversensitive to people not liking me. If they do anything that I think means that - that they don't like me - it's like I suddenly want to curl up into a ball and hide".**

Both also agreed that they tended to compare themselves to people in the general population. One participant thought that it was the staff themselves that discouraged him from mixing with other people with mental health problems.

**"They tell me not to mix with people here. Go and make friends ..... (name) with people outside they say. You know people cannot really be trusted here".**

Both expressed a desire for more contact with people in the general population. One participant thought that it was impossible to make real friends with people in mental health services. Both also agreed that their early relationships in their family, and for one participant her experience of a failed marriage, now made it difficult for them to trust people enough to get close to them.

### **The S group**

Again, the comments made by the two S group participants served to enrich the themes and theory developed in this research rather than suggest a need for modifications or changes.

#### ***(i) Comments on the codes and categories generated in the research***

One participant agreed with almost all the codes and categories generated for the S group in the course of the research. The other agreed with the majority of the codes and categories developed, particularly those developed for participants' responses to the following questions: a) what friends were for; b) ways of making friends; c) the explanations for the interpersonal problems experienced; d) the impact of a participants' emotional difficulties on his/her relationships; and e) the desired role of services. However, she did not feel she avoided people expressing too many needs or emotions nor did she feel that people sometimes got too close.

**"I suppose I disagree with that a bit. I think it's important to listen to people if you can. — listens to my problems so I want to listen to his".**

She also thought that the loneliness that she had experienced before becoming ill had contributed towards the development of her voices and her paranoid thoughts.

**"No-one was around really to stop me doing and thinking strange things. If people had been around they might have helped me sooner".**

#### ***(ii) Comments on the themes generated in the research***

Both participants agreed with most of the themes generated in the research. Both reported periods of loneliness and isolation and both thought that school had been a particularly unhappy time. Both were teased and bullied. Both thought it was difficult to form relationships with people in the general population because of the stigma they experienced from others towards their mental health problems. They also confirmed that almost all their friendships had been formed in the context of mental health services.

**“It’s because I trust people more here. They understand my difficulties and don’t get annoyed when I do things when I’m not well”.**

The only theme that proved controversial was ‘a practical versus an emotional focus towards relationships’. One participant stressed that emotional support was a far more important component of friendship for her than practical support was. Yet, whilst she stressed the importance of emotional support in her life, it was interesting that her responses to the other questions had a far less emotional ‘flavour’ than the responses given by the two participants in the D group.

### ***(iii) An exploration of the emerging analysis***

It was revealing that both participants thought that they often found it difficult to work out what other people were thinking or feeling. One participant said that this contributed to her paranoia.

**“It’s like when I don’t know what people are thinking I start to get paranoid. I get strange and start to think that people want to hurt me or are thinking nasty things about me”**

Both appeared to find it difficult to describe what they believed other people thought of them. One participant said that she didn’t care. When describing the reasons for why they had been bullied at school, both participants gave practical reasons for this.

**“They just did I suppose”.**

**“Because I looked funny I think”**

Both confirmed that it could be difficult to work out what they were really feeling.

**“Yes, it’s like I can’t think straight and my mind becomes clouded. And I suppose I don’t really understand why I feel angry all the time. I suppose that’s why I have the medication - to calm me down”.**